BOARD OF REGISTERED NURSING
Nursing Practice
Agenda Item Summary

AGENDA ITEM: 11.1
DATE: February 20, 2009

ACTION REQUESTED:	Information Only: Report on Practice Committee Goals and Objectives
REQUESTED BY:	Janette Wackerly, MBA, RN Nursing Education Consultant
BACKGROUND:	The 2008 goal accomplishments summary.
NEXT STEP:	Place on Board Agenda.
FINANCIAL IMPLICATIONS, IF ANY:	None
PERSON TO CONTACT:	Janette Wackerly, MBA, RN Nursing Education Consultant (916) 574-7686

BOARD OF REGISTERED NURSING
NURSING PRACTICE

2008/2009 Goals and Objectives

Goal 1.

In support of the consumer's right to quality care, identify and evaluate issues related to registered nursing tasks being performed by unlicensed assistive personnel.

1.1 Take an active role in activities conducted by other agencies and organizations related to unlicensed assistive personnel.

Liaison continues to respond to public inquiry regarding administration of insulin to school children by unlicensed school personnel based on Board approved information which is also available on the Board's website. The document is titled "Administration of Insulin in Schools by Unlicensed Personnel" approved by the Board November 30, 2007. The document was developed in response to the California Department of Education (CDE) legal advisory on rights of students with diabetes in K-12 in California Public School.

November 14, 2008 in Superior Court Sacramento Judge Lloyd Connelly issued a court decision that unlicensed school personnel are not legally authorized to administer insulin contrary to the Department of Education's Legal Advisory. (see January 15, 2008 agenda)

Goal 2.

Promote patient safety as an essential and vital component of quality nursing care.

2.1 Engage and dialogue with recognized national experts in supporting patient safety in what individuals and organizations have done and what remains to be done. For example just culture and root cause analysis, failure mode and effect analysis, human factor and systems factor.

2.2 Monitor patient and resident safety activities as a component of quality nursing care such as health care errors, competency, patient outcomes, stakeholders, nursing shortage, ethics, lifelong learning, nursing standards, licensure, safety legislation, magnet hospitals.

Board staff worked with the Department of Public Health, Licensing and Certification, Pharmacy and Nursing representatives to verify and clarify nursing students authority in Business and Profession Code, BPC, § 2729. The Executive Officer provided a letter to hospitals and nursing schools regarding nursing student practices authorized by BPC 2729. An informational statement "Clinical Learning Experiences Nursing Students" was added to the Board's website.

Goal 3.

Develop and implement processes for the Board to interact with stakeholders to identify current trends and issues in nursing practice and the health care delivery system.

3.1 Actively participate with other public and private organizations and agencies involved with health care to identify common issues and to promote RN scope of practice consistent with the Nursing Practice Act and ensuring consumer safety.

The Committee reviewed Center for American nurses: Lateral Violence and Bullying in the Workplace. In its statement, the Center defines bullying and lateral violence, disruptive behavior, culture of safety, workforce bullying and verbal abuse. The Center adopted position statements which include recommended strategies that nurses, employers/organizations, continuing education and academic programs and nursing researchers can employ to eliminate lateral violence and bulling.

The Committee reviewed CMS February 8, 2008 Hospital Revised Interpretive Guidelines for Hospitals Condition of Participation (Medicare). Sections pertaining to registered nursing practice included influenza and pneumococcal vaccines; verbal orders with nationally accepted read-back verification practice to be implemented for every verbal order; accepting verbal orders by persons authorized to receive verbal orders; patient medical records entries; drugs and biologicals kept in a secure area and locked when appropriate; and pre-post anesthesia evaluation requirements.

Liaison attended Association of Nurse Leaders, ACNL 30th Annual Program, Leadership on Track, February 10-13, 2008 Rancho Mirage, CA.

Liaison attended California Nursing Outcomes Coalition (CalNOC), program titled "Radical Transformation of Nursing Performance Improvement: Responding to Exploding Measurement Demands" April 8-9, 2008 held at the Hilton in Los Angeles.

Liaison attended the 6th Annual Meeting and Conference- "Taking the Long View: Retention of Nurses within the Profession and within the Workplace" held in Denver, Colorado June 11-12, 2008.

Goal 4.

Identify and implement strategies to impact identified trends and issues.

4.1 Provide timely written and/or verbal input on proposed regulations related to health care policies affecting nursing care.

4.2 Collaborate with the Education/Licensing Committee on educational issues/trends and the Legislative Committee on legislation pertaining to nursing practice.

Liaison attended the 2008 NCLEX invitational held on Monday September 8, 2008 in Los Angeles.

Liaison attended the California Association of Colleges of Nursing, "Evidence Based Practice in Nursing Education," held October 6-8, 2008 at the Sir Francis Drake Hotel in San Francisco.

Liaison attended California Institute for Nursing & Health Care, "Magic in Teaching III and 2nd Annual Clinical Simulation Conference," held on November 13-14, 2008.

4.3 Review and revise current BRN advisory statements and recommend new advisory statements as needed to clarify standards of nursing practice.

Nurse Practitioner informational statements on the Website updated to current practice and legislation.

Goal 5.

Develop and implement processes for the Board to interact with stakeholders to identify and evaluate issues related to advanced practice nursing and to promote maximum utilization of advanced practice nursing.

5.1 Support and promote full utilization of advanced practice nurses.

Liaison provided informational statements posting to the Website for Legislation enacted during the 2007-2008 Sessions:

AB 139 (Bass) Chapter 158 Vehicles: Physician medical examination for school bus drivers is amended to include performance of examination by advanced practice nurses. An act to amend Section 12517.2 of the Vehicle Code.

SB 102 (Migden) Chapter 88 Blood Transfusions: nurse practitioners and nurse midwives who are authorized to order a blood transfusion and can inform the patient by means of a standardized written summary.

5.2 Monitor trends and growing opportunities for advanced practice nursing in areas of health promotion, prevention and managing patients through the continuum of care.

Liaison attended California Association for Nurse Practitioner program titled "Bridging the Health Care Needs" held on March 7-8, 2008 in Paradise Point, San Diego.

Liaison attended The Clinical Nurse Leader Initiate in California, "Improving the Healthcare System," August 8, 2008 at the University of San Francisco.

5.3 Actively participate with organizations and agencies focusing on advanced practice nursing.

The Practice Committee at its March 20, 2008 meeting reviewed:

(a) California HealthCare Foundation, January 2008: Scope of Practice Laws in Health Care: Rethinking the Role of the Nurse Practitioners.
(b) The Center for the Health Professions, UCSF, 2007 Overview of Nurse Practitioner Scopes in the United States.

5.4 In collaboration with the Education/Licensing Committee remain actively involved in facilitating communication and work in progress for education/certification function and communication with advanced practice educational program directors, professional organizations, state agencies and other groups.

Liaison provided informational statement posting to the Website for Legislation enacted during the 2007-2008 Session.

AB 1559 (Berryhill) Chapter 712 Post Secondary Education: authorizing Community College Registered Nursing Programs to implement multiple screening processes to evaluate applicants for admission to the nursing program, use approved diagnostic assessment tools, and to report program admissions policies to the Chancellors office.

SB 1393 (Scott) Chapter 522 Nursing Education: Prevents a registered nursing student who has a baccalaureate degree or higher degree from a regionally accredited institution of higher learning from having to complete general education requirements.

BOARD OF REGISTERED NURSING
Nursing Practice
Agenda Item Summary

AGENDA ITEM: 11.2
DATE: February 20, 2009

ACTION REQUESTED: Information and Discussion: Alignment of California APRN Rules and Regulation: National Council Model for APRN Regulation, Licensure, Accreditation, and Certification

REQUESTED BY: Janette Wackerly, MBA, RN
Nursing Education Consultant

BACKGROUND: Business and Professions Code Section 2725.5 "Advanced Practice Nurse"

The Committee may elect to evaluate the APRN Regulatory Model that includes the essential elements: licensure, accreditation, certification and education (LACE). Attached. The Committee may elect to consult California stakeholders for readiness to discuss the components of the proposed model and if ready to discuss implementation strategies.

BPC Section 2725.5 Advanced practice registered nurse means those licensed registered nurses who have met the requirements including nurse practitioner (NP), nurse-midwives (CNM), nurse anesthetists (CRNA) and clinical nurse specialists (CNS) can use the title "Advanced Practice Nurse". BRN rules and regulations for each category of advanced practice nurse defines the legal scope of practice, the roles that are recognized, the criteria for entry-into advanced practice and any certification requirements. The advanced practice nurses in California are registered nurses with a certification as an NP, CNM, CRNA, and CNS.

The APRN model identifies four roles: NP, CNM, CRNA, CNS and education for the four roles occur in an academic degree program or post graduate education. The APRN model identifies at least six population foci that include psych/mental health, gender specific, adult-gerontology, pediatrics, neonatal and individual/family across the life span. The APRN education programs are broad based including graduate-level courses in advanced physiology/pathophysiology, health assessment, and pharmacology as well as appropriate clinical experience. BRN may by regulation consider adding the foci groups specifically and recognition of the three core graduate-level courses for all advanced practice nurses.

The APRN model includes certification examination to access national competencies for the APRN core, role and at least one population foci. The APRN model statement is that education, certification, and licensure of an individual must be congruent in terms of role and population foci. BRN application for the four roles uses national certification as a method to receive California certification as an advanced practice nurse but does not mandate national certification. Completion of a California approved advanced practice education program is utilized by the BRN for certification.

The APRN model states that individuals will be licensed as independent practitioners for practice at the level of one of the four APRN roles within at least one of the six identified population foci. BRN laws and regulations do not identify the four APRN roles as licensed independent practitioners. Licensed independent practitioners for any of the four APRN roles would necessarily require legislation.

NEXT STEP:	Place on Board Agenda.
FINANCIAL IMPLICATIONS, IF ANY:	None
PERSON TO CONTACT:	Janette Wackerly, MBA, RN Nursing Education Consultant (916) 574-7686

Consensus Model for APRN Regulation: Licensure, Accreditation, Certification & Education

June 18, 2008

Completed through the work of the APRN Consensus Work Group & the National Council of State Boards of Nursing APRN Advisory Committee

INTRODUCTION

Advanced Practice Registered Nurses (APRNs) have expanded in numbers and capabilities over the past several decades with APRNs being highly valued and an integral part of the health care system. Because of the importance of APRNs in caring for the current and future health needs of patients, the education, accreditation, certification and licensure of APRNs need to be effectively aligned in order to continue to ensure patient safety while expanding patient access to APRNs.

APRNs include certified registered nurse anesthetists, certified nurse-midwives, clinical nurse specialists and certified nurse practitioners. Each has a unique history and context, but share the commonality of being APRNs. While education, accreditation, and certification are necessary components of an overall approach to preparing an APRN for practice, the licensing boards, governed by state regulations and statutes, are the final arbiters of who is recognized to practice within a given state. Currently, there is no uniform model of regulation of APRNs across the states. Each state independently determines the APRN legal scope of practice, the roles that are recognized, the criteria for entry-into advanced practice and the certification examinations accepted for entry-level competence assessment. This has created a significant barrier for APRNs to easily move from state to state and has decreased access to care for patients.

Many nurses with advanced graduate nursing preparation practice in roles and specialties, such as nurses in informatics, public health, education or administration, while essential to advance the health of the public, do not focus on direct care to individuals and, therefore, whose practice does not require regulatory recognition beyond the Registered Nurse license granted by state boards of nursing. Like the current four APRN roles, practice in these other advanced specialty nursing roles requires specialized knowledge and skills acquired through graduate-level education. Although extremely important to the nursing profession and to the delivery of safe, high quality patient care, these other advanced, graduate nursing roles, who do not focus on direct patient care, are not Advanced Practice Registered Nurses (APRN) and are not the subject or focus of the Regulatory Model presented in this paper.

The model for APRN regulation is the product of substantial work conducted by the Advanced Practice Nursing Consensus Work Group and the National Council of State Boards of Nursing (NCSBN) APRN Committee. While these groups began work independent of each other, they came together through representatives of each group participating in what was labeled the APRN Joint Dialogue Group. The outcome of this work has been unanimous agreement on most of the recommendations included in this document. In a few instances, when agreement was not unanimous a 66% majority was used to determine the final recommendation. However, extensive dialogue and transparency in the decision making process is reflected in each recommendation. The background of each group can be found on pages 13-16 and individual and organizational participants in each group in Appendices C-H.

This document defines APRN practice, describes the APRN regulatory model, identifies the titles to be used, defines specialty, describes the emergence of new roles and population foci, and presents strategies for implementation.

Overview of APRN Model of Regulation

The APRN Model of Regulation described will be the model of the future. It is recognized that current regulation of APRNs does not reflect all of the components described in this paper and will evolve incrementally over time. A proposed timeline for implementation is presented at the end of the paper.

In this APRN model of regulation there are four roles: certified registered nurse anesthetist (CRNA), certified nurse-midwife (CNM), clinical nurse specialist (CNS), and certified nurse practitioner (CNP). These four roles are given the title of advanced practice registered nurse (APRN). APRNs are educated in one of the four roles and in at least one of six population foci: family/individual across the lifespan, adult-gerontology, pediatrics, neonatal, women's health/gender-related or psych/mental health. APRN education programs, including degree-granting and post-graduate education programs[1], are accredited. APRN education consists of a broad-based education, including three separate graduate-level courses in advanced physiology/pathophysiology, health assessment and pharmacology as well as appropriate clinical experiences. All developing APRN education programs or tracks go through a pre-approval, pre-accreditation or accreditation process prior to admitting students. APRN education programs must be housed within graduate programs that are nationally accredited[2] and their graduates must be eligible for national certification used for state licensure.

Individuals who have the appropriate education will sit for a certification examination to assess national competencies of the APRN core, role and at least one population focus area of practice for regulatory purposes. APRN certification programs will be accredited by a national certification accrediting body[3]. APRN certification programs will require a continued competency mechanism.

Individuals will be licensed as independent practitioners for practice at the level of one of the four APRN roles within at least one of the six identified population foci. Education, certification, and licensure of an individual must be congruent in terms of role and population foci. APRNs may specialize but they can not be licensed solely within a specialty area. *In addition, specialties can provide depth in one's practice within the established population*

[1] Degree granting programs include master's and doctoral programs. Post-graduate programs include both post-master's and post-doctoral certificate education programs.

[2] APRN education programs must be accredited by a nursing accrediting organization that is recognized by the U.S. Department of Education (USDE) and/or the Council for Higher Education Accreditation (CHEA), including the Commission on Collegiate Nursing Education (CCNE), National League for Nursing Accrediting Commission (NLNAC), Council on Accreditation of Nurse Anesthesia Educational Programs (COA), Division of Accreditation of the American College of Nurse-Midwives, and the National Association of Nurse Practitioners in Women's Health Council on Accreditation.

[3] The certification program should be nationally accredited by the American Board of Nursing Specialties (ABNS) or the National Commission for Certifying Agencies (NCCA).

foci. Education and assessment strategies for specialty areas will be developed by the nursing profession, i.e. nursing organizations and special interest groups. Education for a specialty can occur concurrently with APRN education required for licensure or through post-graduate education. Competence at the specialty level will not be assessed or regulated by boards of nursing but rather by the professional organizations.

In addition, a mechanism that enhances the communication and transparency among APRN licensure, accreditation, certification and education bodies (LACE) will be developed and supported.

APRN REGULATORY MODEL

APRN Regulation includes the essential elements: licensure, accreditation, certification and education (LACE).

- Licensure is the granting of authority to practice.
- Accreditation is the formal review and approval by a recognized agency of educational degree programs in nursing or certification programs.
- Certification is the formal recognition of the knowledge, skills, and experience demonstrated by the achievement of standards identified by the profession.
- Education is the formal preparation of APRNs in graduate degree-granting or post-graduate certificate programs.

The APRN Regulatory Model applies to all elements of LACE. Each of these elements plays an essential part in the implementation of the model.

Definition of Advanced Practice Registered Nurse

Characteristics of the advanced practice registered nurse (APRN) were identified and several definitions of an APRN were considered, including the NCSBN and the American Nurses Association (ANA) definitions, as well as others. The characteristics identified aligned closely with these existing definitions. The definition of an APRN, delineated in this document, includes language that addresses responsibility and accountability for health promotion and the assessment, diagnosis, and management of patient problems which includes the use and prescription of pharmacologic and non-pharmacologic interventions.

The definition of an Advanced Practice Registered Nurse (APRN) is a nurse:

1. who has completed an accredited graduate-level education program preparing him/her for one of the four recognized APRN roles;
2. who has passed a national certification examination that measures APRN, role and population-focused competencies and who maintains continued competence as evidenced by recertification in the role and population through the national certification program;
3. who has acquired advanced clinical knowledge and skills preparing him/her to provide direct care to patients, as well as a component of indirect care; however, the defining factor for **all** APRNs is that a significant component of the education and practice focuses on direct care of individuals;

4. whose practice builds on the competencies of registered nurses (RNs) by demonstrating a greater depth and breadth of knowledge, a greater synthesis of data, increased complexity of skills and interventions, and greater role autonomy;
5. who is educationally prepared to assume responsibility and accountability for health promotion and/or maintenance as well as the assessment, diagnosis, and management of patient problems which includes the use and prescription of pharmacologic and non-pharmacologic interventions;
6. who has clinical experience of sufficient depth and breadth to reflect the intended license; **and**
7. who has obtained a license to practice as an APRN in one of the four APRN roles: certified registered nurse anesthetist (CRNA), certified nurse-midwife (CNM), clinical nurse specialist (CNS), or certified nurse practitioner (CNP).

Advanced practice registered nurses are licensed independent practitioners who are expected to practice within standards established or recognized by a licensing body. Each APRN is accountable to patients, the nursing profession and the licensing board to comply with the requirements of the state nurse practice act and the quality of advanced nursing care rendered; for recognizing limits of knowledge and experience, planning for the management of situations beyond the APRN's expertise; and for consulting with or referring patients to other health care providers as appropriate.

All APRNs are educationally prepared to provide a scope of services across the health wellness-illness continuum to at least one population focus as defined by nationally-recognized role and population-focused competencies; however, the emphasis and implementation within each APRN role varies. The services or care provided by APRNs is not defined or limited by setting but rather patient care needs. The continuum encompasses the range of health states from homeostasis (or wellness) to a disruption in the state of health in which basic needs are not met or maintained (illness), with health problems of varying acuity occurring along the continuum that must be prevented or resolved to maintain wellness or an optimal level of functioning (WHO, 2006). Although all APRNs are educationally prepared to provide care to patients across the health wellness-illness continuum, the emphasis and how implemented within each APRN role varies.

The Certified Registered Nurse Anesthetist

The Certified Registered Nurse Anesthetist is prepared to provide the full spectrum of patients' anesthesia care and anesthesia-related care for individuals across the lifespan, whose health status may range from healthy through all recognized levels of acuity, including persons with immediate, severe, or life-threatening illnesses or injury. This care is provided in diverse settings, including hospital surgical suites and obstetrical delivery rooms; critical access hospitals; acute care; pain management centers; ambulatory surgical centers; the offices of dentists, podiatrists; ophthalmologists, and plastic surgeons.

The Certified Nurse-Midwife

The certified nurse-midwife provides a full range of primary health care services to women throughout the lifespan, including gynecologic care, family planning services, preconception care, prenatal and postpartum care, childbirth and care of the newborn. The practice includes

treating the male partner of their female clients for sexually transmitted disease and reproductive health. This care is provided in diverse settings which may include home, hospital, birth center, and a variety of ambulatory care settings including private offices, community and public health clinics.

The Clinical Nurse Specialist

The CNS has a unique APRN role to integrate care across the continuum and through three spheres of influence: patient, nurse, system. The three spheres are overlapping and interrelated but each sphere possesses a distinctive focus. In each of the spheres of influence, the primary goal of the CNS is continuous improvement of patient outcomes and nursing care. Key elements of CNS practice are to create environments through mentoring and system changes that empower nurses to develop caring, evidence-based practices to alleviate patient distress, facilitate ethical decision-making and respond to diversity. The CNS is responsible and accountable for diagnosis and treatment of health/illness states, disease management, health promotion, prevention of illness and risk behaviors among individuals, families, groups and communities.

The Certified Nurse Practitioner

For the certified nurse practitioner (CNP), care along the wellness-illness continuum is a dynamic process in which direct primary and acute care is provided across settings. CNPs are members of the health delivery system, practicing autonomously in areas as diverse as family practice, pediatrics, internal medicine, geriatrics and women's health care. CNPs are prepared to diagnose and treat patients with undifferentiated symptoms as well as those with established diagnoses. Both primary and acute care CNPs provide initial, ongoing and comprehensive care that includes taking comprehensive histories, providing physical examinations and other health assessment and screening activities, and diagnosing, treating and managing patients with acute and chronic illnesses and diseases. This includes ordering, performing, supervising and interpreting laboratory tests and Xrays, prescribing medication and durable medical equipment and making appropriate referrals for patients and families. Clinical CNP care includes health promotion, disease prevention, health education and counseling as well as the diagnosis and management of acute and chronic diseases. Certified nurse practitioners are prepared to practice as primary care CNPs and acute care CNPs which have separate national consensus-based competencies and separate certification processes.

Titling

The title, Advanced Practice Registered Nurse (APRN) is the licensing title to be used for the subset of nurses prepared with advanced, graduate-level nursing knowledge to provide direct patient care in four roles: certified registered nurse anesthetist, certified nurse-midwife, clinical nurse specialist, and certified nurse practitioner.[4] This title, APRN, is a legally

[4] Nurses with advanced graduate nursing preparation practicing in roles and specialties that do not provide direct care to individuals and, therefore, whose practice does not require regulatory recognition beyond the Registered Nurse license granted by state boards of nursing may not use any term or title which may confuse the public, including advanced practice nurse or advanced practice registered nurse. The term, advanced public health nursing, however, may be used to identify nurses practicing in this advanced specialty area of nursing.

protected title. Licensure and scope of practice are based on graduate education in one of the four roles and in a defined population.

Verification of licensure, whether hard copy or electronic, will indicate the role and population for which the APRN has been licensed.

At a minimum, an individual must legally represent themselves, including in a legal signature, as an APRN and by the role. He/she may indicate the population as well. No one, except those who are licensed to practice as an APRN, may use the APRN title or any of the APRN role titles.

An individual also may add the specialty title in which they are professionally recognized in addition to the legal title of APRN and role.

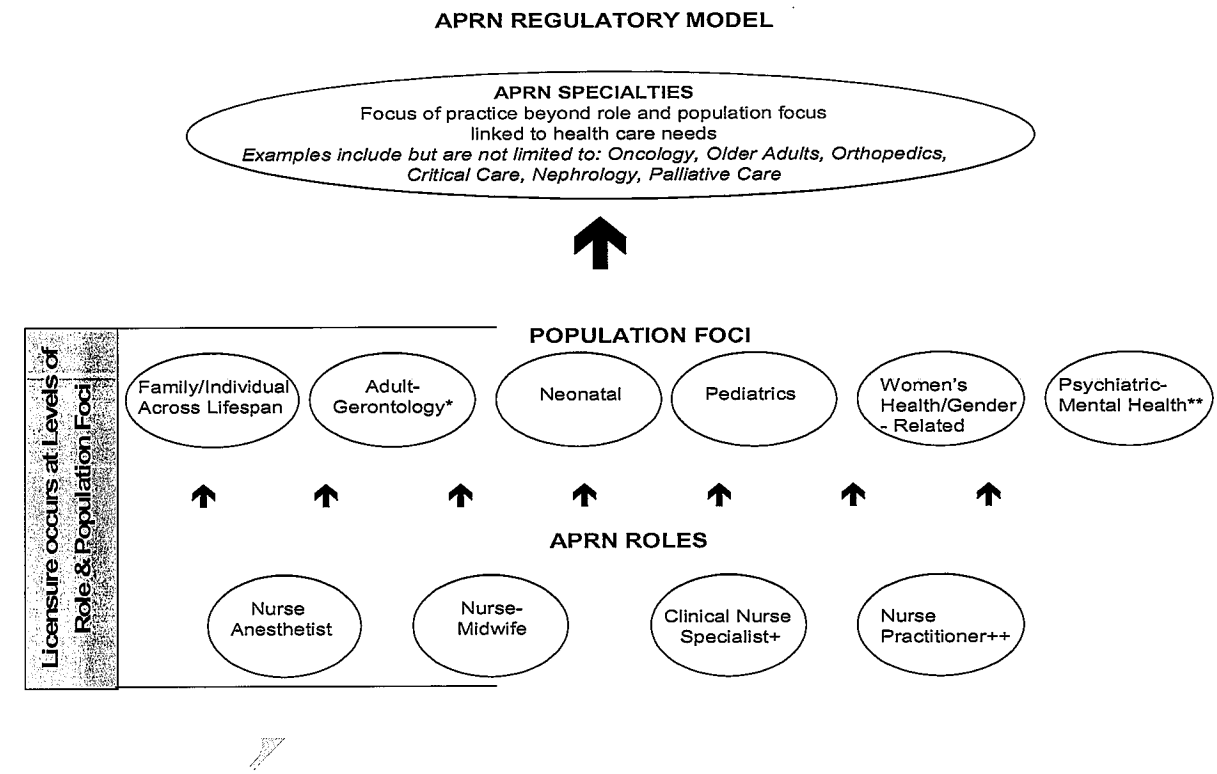


Diagram 1: APRN Regulatory Model

Under this APRN Regulatory Model, there are four roles: certified registered nurse anesthetist (CRNA), certified nurse-midwife (CNM), clinical nurse specialist (CNS), and certified nurse practitioner (CNP). These four roles are given the title of advanced practice registered nurse (APRN). APRNs are educated in one of the four roles and in at least one of six population foci: family/individual across the lifespan, adult-gerontology, neonatal, pediatrics, women's health/gender-related or psych/mental health. Individuals will be licensed as independent practitioners for practice at the level of one of the four APRN roles within at least one of the six identified population foci. Education, certification, and licensure of an individual must be congruent in terms of role and population foci. APRNs may specialize but they can not be licensed solely within a specialty area. Specialties can provide depth in one's practice within the established population foci.

* The population focus, adult-gerontology, encompasses the young adult to the older adult, including the frail elderly. APRNs educated and certified in the adult-gerontology population are educated and certified across both areas of practice and will be titled Adult-Gerontology CNP or CNS. In addition, all APRNs in any of the four roles providing care to the adult population, e.g. family or gender specific, must be prepared to meet the growing needs of the older adult population. Therefore, the education program should include didactic and clinical education experiences necessary to prepare APRNs with these enhanced skills and knowledge.

** The population focus, psychiatric/mental health, encompasses education and practice across the lifespan.

+ The Clinical Nurse Specialist (CNS) is educated and assessed through national certification processes across the continuum from wellness through acute care.

++The certified nurse practitioner (CNP) is prepared with the acute care CNP competencies and/or the primary care CNP competencies. At this point in time the acute care and primary care CNP delineation applies only to the pediatric and adult-gerontology CNP population foci. Scope of practice of the primary care or acute care CNP is **not setting specific** but is based on patient care needs. Programs may prepare individuals across both the primary care and acute care CNP competencies. If programs prepare graduates across both sets of roles, the graduate must be prepared with the consensus-based competencies for both roles and must successfully obtain certification in both the acute and the primary care CNP roles.

Broad-based APRN Education

For entry into APRN practice and for regulatory purposes, APRN education must:

- be formal education with a graduate degree or post-graduate certificate (either post-master's or post-doctoral) that is awarded by an academic institution and accredited by a nursing or nursing related accrediting organization recognized by the U.S. Department of Education (USDE) and/or the Council for Higher Education Accreditation (CHEA);
- be awarded pre-approval, pre-accreditation or accreditation status prior to admitting students;
- be comprehensive and at the graduate level;
- prepare the graduate to practice in one of the four identified APRN roles;
- prepare the graduate with the core competencies for one of the APRN roles across *at least one* of the six population foci;
- include at a minimum, three separate comprehensive ***graduate-level*** courses (the APRN Core) in:
    - Advanced physiology/pathophysiology, including general principles that apply across the lifespan;
    - Advanced health assessment which includes assessment of all human systems, advanced assessment techniques, concepts and approaches; and
    - Advanced pharmacology which includes pharmacodynamics, pharmacokinetics and pharmacotherapeutics of all broad categories of agents.
- Additional content, specific to the role and population, in these three APRN core areas should be integrated throughout the other role and population didactic and clinical courses;
- Provide a basic understanding of the principles for decision making in the identified role;

- Prepare the graduate to assume responsibility and accountability for health promotion and/or maintenance as well as the assessment, diagnosis, and management of patient problems which includes the use and prescription of pharmacologic and non-pharmacologic interventions; and
- Ensure clinical and didactic coursework is comprehensive and sufficient to prepare the graduate to practice in the APRN role and population focus.

Preparation in a specialty area of practice is optional but if included must build on the APRN role/population-focus competencies. Clinical and didactic coursework must be comprehensive and sufficient to prepare the graduate to obtain certification for licensure in and to practice in the APRN role and population focus.

As part of the accreditation process, all APRN education programs must undergo a pre-approval, pre-accreditation or accreditation process prior to admitting students. The purpose of the pre-approval process is twofold: 1) to ensure that students graduating from the program will be able to meet the education criteria necessary for national certification in the role and population-focus and if successfully certified, are eligible for licensure to practice in the APRN role/population-focus; and 2) to assure that programs will meet all educational standards prior to starting the program. The pre-approval, pre-accreditation or accreditation processes may vary across APRN roles.

APRN Specialties

Preparation in a specialty area of practice is optional, but if included must build on the APRN role/population-focused competencies. Specialty practice represents a much more focused area of preparation and practice than does the APRN role/population focus level. Specialty practice may focus on specific patient populations beyond those identified or health care needs such as oncology, palliative care, substance abuse or nephrology. The criteria for defining an APRN specialty is built upon the ANA (2004) Criteria for Recognition as a Nursing Specialty (see Appendix B). APRN specialty education and practice build upon and are in addition to the education and practice of the APRN role and population focus. For example, a family CNP could specialize in elder care or nephrology; an Adult-Gerontology CNS could specialize in palliative care; a CRNA could specialize in pain management; or a CNM could specialize in care of the post-menopausal woman. State licensing boards will not regulate the APRN at the level of specialties in this APRN Regulatory Model. Professional certification in the specialty area of practice is strongly recommended.

An APRN specialty

- preparation can not replace educational preparation in the role or one of the six population foci;
- preparation can not expand one's scope of practice beyond the role or population focus
- addresses a subset of the population-focus;
- title may not be used in lieu of the licensing title which includes the role or role/population; and
- is developed, recognized and monitored by the profession.

New specialties emerge based on health needs of the population. APRN specialties develop to provide added value to the role practice as well as providing flexibility within the profession to meet these emerging needs of patients. Specialties also may cross several or all APRN roles. A specialty evolves out of an APRN role/population focus and indicates that an APRN has *additional* knowledge and expertise in a more discrete area of specialty practice. Competency in the specialty areas could be acquired either by educational preparation or experience and assessed in a variety of ways through professional credentialing mechanisms, such as portfolios, examinations, etc.

Education programs may concurrently prepare individuals in a specialty providing they meet all of the other requirements for APRN education programs, including preparation in the APRN core, role and population core competencies. In addition, for licensure purposes, one exam must assess the APRN core, role and population-focused competencies. For example, a nurse anesthetist would write one certification examination, which tests the APRN core, CRNA role and population-focused competencies, administered by the Council on Certification for Nurse Anesthetist; or a primary care family nurse practitioner would write one certification examination, which tests the APRN core, CNP role and family population-focused competencies, administered by ANCC or AANP. Specialty competencies must be assessed separately. In summary, education programs preparing individuals with this additional knowledge in a specialty, *if used for entry into advanced practice registered nursing and for regulatory purposes*, must also prepare individuals in one of the four nationally recognized APRN roles and in one of the six population foci. Individuals must be recognized and credentialed in one of the four APRN roles within at least one population foci. APRNs are licensed at the role/population focus level and **not** at the specialty level. However, if not intended for entry-level preparation in one of the four roles/population foci and not for regulatory purposes, education programs, using a variety of formats and methodologies, may provide licensed APRNs with the additional knowledge, skills and abilities, to become professionally certified in the specialty area of APRN practice.

Emergence of New APRN Roles and Population-Foci

As nursing practice evolves and health care needs of the population change, new APRN roles or population-foci may evolve over time. An APRN role would encompass a unique or significantly differentiated set of competencies from any of the other APRN roles. In addition, the scope of practice within the role or population focus is not entirely subsumed within one of the other roles. Careful consideration of new APRN roles or population-foci is in the best interest of the profession.

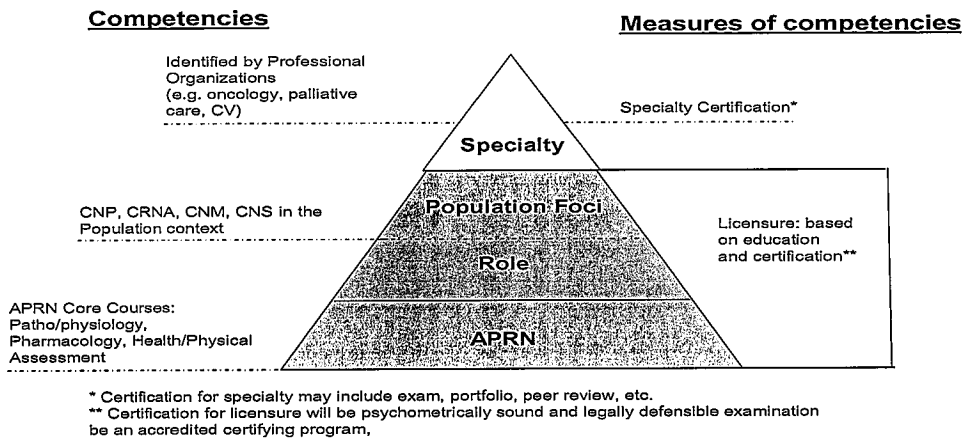
For licensure, there must be clear guidance for national recognition of a new APRN role or population-focus. A new role or population focus should be discussed and vetted through the national licensure, accreditation, certification, education communication structure, LACE. An essential part of being recognized as a role or population-focus is that educational standards and practice competencies must exist, be consistent, and must be nationally recognized by the profession. Characteristics of the process to be used to develop nationally

recognized core competencies, and education and practice standards for a newly emerging role or population-focus are:

1. National in scope
2. Inclusive
3. Transparent
4. Accountable
5. Initiated by nursing
6. Consistent with national standards for licensure, accreditation, certification and education
7. Evidence-based
8. Consistent with regulatory principles.

To be recognized, an APRN role must meet the following criteria:

- Nationally recognized education standards and core competencies for programs preparing individuals in the role;
- Education programs, including graduate degree granting (master's, doctoral) and post-graduate certificate programs, are accredited by a nursing accrediting organization that is recognized by the U.S. Department of Education (USDE) and/or the Council for Higher Education Accreditation (CHEA); and
- Professional nursing certification program which is psychometrically sound, legally defensible and which meets nationally recognized accreditation standards for certification programs.[5]



[5] The professional certification program should be nationally accredited by the American Board of Nursing Specialties (ABNS) or the National Commission for Certifying Agencies (NCCA).

Diagram 2: Relationship Among Educational Competencies, Licensure, & Certification in the Role/Population Foci and Education and Credentialing in a Specialty

IMPLEMENTATION STRATEGIES FOR APRN REGULATORY MODEL

In order to accomplish the above model, the four prongs of regulation: licensure, accreditation, certification and education (LACE) must work together. Expectations for licensure, accreditation, certification, and education are listed below:

Foundational Requirements for Licensure

Boards of nursing will:

1. license APRNs in the categories of Certified Registered Nurse Anesthetist, Certified Nurse-Midwife, Clinical Nurse Specialist or Certified Nurse Practitioner within a specific population focus;
2. be solely responsible for licensing Advanced Practice Registered Nurses[6];
3. only license graduates of accredited graduate programs that prepare graduates with the APRN core, role and population competencies;
4. require successful completion of a national certification examination that assesses APRN core, role and population competencies for APRN licensure.
5. not issue a temporary license;
6. only license an APRN when education and certification are congruent;
7. license APRNs as independent practitioners with no regulatory requirements for collaboration, direction or supervision;
8. allow for mutual recognition of advanced practice registered nursing through the APRN Compact;
9. have at least one APRN representative position on the board and utilize an APRN advisory committee which includes representatives of all four APRN roles; and,
10. institute a grandfathering[7] clause which will exempt those APRNs already practicing in the state from new eligibility requirements.

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[6] Except in states where state boards of nurse-midwifery or midwifery regulate nurse-midwives or nurse-midwives and midwives jointly.

[7] Grandfathering is a provision in a new law exempting those already in or a part of the existing system that is being regulated. When states adopt new eligibility requirements for APRNs, currently practicing APRNs will be permitted to continue practicing within the state(s) of their current licensure.
However, if an APRN applies for licensure by endorsement in another state, the APRN would be eligible for licensure if s/he demonstrates that the following criteria have been met:

- current, active practice in the advanced role and population focus area,
- current active, national certification or recertification, as applicable, in the advanced role and population focus area,
- compliance with the APRN educational requirements of the state in which the APRN is applying for licensure that were in effect at the time the APRN completed his/her APRN education program, and
- compliance with all other criteria set forth by the state in which the APRN is applying for licensure (e.g. recent CE, RN licensure).

Once the model has been adopted and implemented (date to be determined by the state boards of nursing. See proposed timeline on page 14-15.) all new graduates applying for APRN licensure must meet the requirements outlined in this regulatory model

Foundational Requirements for Accreditation of Education Programs

Accreditors will:

1. be responsible for evaluating APRN education programs including graduate degree-granting and post-graduate certificate programs.[8].
2. through their established accreditation standards and process, assess APRN education programs in light of the APRN core, role core, and population core competencies;
3. assess developing APRN education programs and tracks by reviewing them using established accreditation standards and granting pre-approval, pre-accreditation or accreditation prior to student enrollment;
4. include an APRN on the visiting team when an APRN program/track is being reviewed; and
5. monitor APRN educational programs throughout the accreditation period by reviewing them using established accreditation standards and processes.

Foundational Requirements for Certification

Certification programs providing APRN certification used for licensure will:

1. follow established certification testing and psychometrically sound, legally defensible standards for APRN examinations for licensure. (see appendix A for the NCSBN Criteria for APRN Certification Programs);
2. assess the APRN core and role competencies across at least one population focus of practice;
3. certification used for regulatory purposes must demonstrate in the test blueprint that the APRN, role and population-focused competencies are assessed
4. delineate separately from the APRN core, role and population-focused competencies in the test blue print, if specialty content is tested in the same examination, what specialty competencies are tested
5. be accredited by a national certification accreditation body;[9]
6. enforce congruence (role and population focus) between the education program and the type of certification examination;
7. provide a mechanism to ensure ongoing competence and maintenance of certification;
8. participate in ongoing relationships which make their processes transparent to boards of nursing;
9. participate in a mutually agreeable mechanism to ensure communication with boards of nursing and schools of nursing.

Foundational Requirements for Education

APRN education programs/tracks leading to APRN licensure, including graduate degree-granting and post-graduate certificate programs will:

[8] Degree-granting programs include both master's and doctoral programs. Post-graduate certificate programs include post-master's and post-doctoral education programs.

[9] The certification program should be nationally accredited by the American Board of Nursing Specialties (ABNS) or the National Commission for Certifying Agencies (NCCA).

1. follow established educational standards and ensure attainment of the APRN core, role core and population core competencies[10,11]
2. be accredited by a nursing accrediting organization that is recognized by the U.S. Department of Education (USDE) and/or the Council for Higher Education Accreditation (CHEA). [12]
3. be pre-approved, pre-accredited or accredited prior to the acceptance of students, including all developing APRN education programs and tracks;
4. ensure that graduates of the program are eligible for national certification and state licensure; and
5. ensure that official documentation (e.g. transcript) specifies the role and population focus of the graduate.

Communication Strategies

A formal communication mechanism, LACE, which includes those regulatory organizations that represent APRN licensure, accreditation, certification, and education entities would be created. The purpose of LACE would be to provide a formal, ongoing communication mechanism that provides for transparent and aligned communication among the identified entities. The collaborative efforts between the APRN Consensus Group and the NCSBN APRN Advisory Panel, through the APRN Joint Dialogue Group have illustrated the ongoing level of communication necessary among these groups to ensure that all APRN stakeholders are involved. Several strategies including equal representation on an integrated board with face-to-face meetings, audio and webcast conferencing, pass protected access to agency websites, and regular reporting mechanisms have been recommended. These strategies will build trust and enhance information sharing. Examples of issues to be addressed by the group would be: guaranteeing appropriate representation of APRN roles among accreditation site visitors, documentation of program completion by education institutions, notification of examination outcomes to educators and regulators, notification of disciplinary action toward licensees by boards of nursing.

Creating the LACE Structure and Processes

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[10] The APRN core competencies for all APRN nursing education programs located in schools of nursing are delineated in the American Association of Colleges of Nursing (1996) *The Essentials of Master's Education for Advanced Practice Nursing Education* or the AACN (2006) *The Essentials of Doctoral Education for Advanced Nursing Practice*. The APRN core competencies for nurse anesthesia and nurse-midwifery education programs located outside of a school of nursing are delineated by the accrediting organizations for their respective roles i.e., Council on Accreditation of Nurse Anesthesia Educational Programs (COA), American College of Nurse-Midwives Division of Accreditation (ACNMDOA).

[11] APRN programs outside of schools of nursing must prepare graduates with the APRN core which includes three separate graduate-level courses in pathophysiology/physiology, health assessment, and pharmacology.

[12] APRN education programs must be accredited by a nursing accrediting organization that is recognized by the U.S. Department of Education (USDE) and/or the Council for Higher Education Accreditation (CHEA), including the Commission on Collegiate Nursing Education (CCNE), National League for Nursing Accrediting Commission (NLNAC), Council on Accreditation of Nurse Anesthesia Educational Programs (COA), Division of Accreditation of the American College of Nurse-Midwives, and the National Association of Nurse Practitioners in Women's Health Council on Accreditation.

Several principles should guide the formulation of a structure including: 1) all four entities of LACE should have representation; 2) the total should allow effective discussion of and response to issues and ; 3) the structure should not be duplicative of existing structures such as the Alliance for APRN Credentialing. Consideration should be given to evolving the existing Alliance structure to meet the needs of LACE. Guidance from an organizational consultant will be useful in forming a permanent structure that will endure and support the work that needs to continue. The new structure will support fair decision-making among all relevant stakeholders. In addition, the new structure will be in place as soon as possible.

The LACE organizational structure should include representation of:

- State licensing boards, including at least one compact and one non-compact state;
- Accrediting bodies that accredit education programs of the four APRN roles;
- Certifying bodies that offer APRN certification used for regulatory purposes; and,
- Education organizations that set standards for APRN education.

Timeline for Implementation of Regulatory Model

Implementation of the recommendations for an APRN Regulatory Model will occur incrementally. Due to the interdependence of licensure, accreditation, certification and education, certain recommendations will be implemented sequentially. However, recognizing that this model was developed through a consensus process with participation of APRN certifiers, accreditors, public regulators, educators, and employers, it is expected that the recommendations and model delineated will inform decisions made by each of these entities as the APRN community moves to fully implement the APRN Regulatory Model. A target date for full implementation of the Regulatory Model and all embedded recommendations is the Year 2015.

HISTORICAL BACKGROUND

NCSBN APRN Committee (previously APRN Advisory Panel)

NCSBN became involved with advanced practice nursing when boards of nursing began using the results of APRN certification examinations as one of the requirements for APRN licensure. During the 1993 NCSBN annual meeting, delegates adopted a position paper on the licensure of advanced nursing practice which included model legislation language and model administrative rules for advanced nursing practice. NCSBN core competencies for certified nurse practitioners were adopted the following year.

In 1995, NCSBN was directed by the Delegate Assembly to work with APRN certifiers to make certification examinations suitable for regulatory purposes. Since then, much effort has been made toward that purpose. During the mid and late 90's, the APRN certifiers agreed to undergo accreditation and provide additional information to boards of nursing to ensure that their examinations were psychometrically sound and legally defensible. (NCSBN, 1998)

During the early 2000's, the APRN Advisory Panel developed criteria for ARPN certification programs and for accreditations agencies. In January 2002, the Board of Directors approved

the criteria and process for a new review process for APRN certification programs. The criteria represented required elements of certification programs that would result in a legally defensible examination suitable for the regulation of advanced practice nurses. Subsequently, the APRN Advisory Panel has worked with certification programs to improve the legal defensibility of APRN certification examinations and to promote communication with all APRN stakeholders regarding APRN regulatory issues such as with the establishment of the annual NCSBN APRN Roundtable in the mid 1990's. In 2002, the Advisory Panel also developed a position paper describing APRN regulatory issues of concern.

In 2003, the APRN Advisory Panel began a draft APRN Vision Paper in an attempt to resolve APRN regulatory concerns such as the proliferation of APRN subspecialty areas. The purpose of the APRN Vision Paper was to provide direction to boards of nursing regarding APRN regulation for the next eight to ten years by identifying an ideal future APRN regulatory model. Eight recommendations were made. The draft vision paper was completed in 2006. After reviewing the draft APRN Vision Paper at their February 2006 board meeting, the board of directors directed that the paper be disseminated to boards of nursing and APRN stakeholders for feedback. The Vision paper also was discussed during the 2006 APRN Roundtable. The large response from boards of nursing and APRN stakeholders was varied. The APRN Advisory Panel spent the remaining part of 2006, reviewing and discussing the feedback with APRN stakeholders. (See Appendix C for the list of APRN Advisory Panel members who worked on the draft APRN Vision Paper and Appendix D for the list of organizations represented at the 2006 APRN Roundtable where the draft Vision Paper was presented.)

APRN Consensus Group

In March 2004, the American Association of Colleges of Nursing (AACN) and the National Organization of Nurse Practitioner Faculties (NONPF) submitted a proposal to the Alliance for Nursing Accreditation, now named Alliance for APRN Credentialing[13] (hereafter referred to as "the APRN Alliance") to establish a process to develop a consensus[14] statement on the credentialing of advanced practice nurses (APNs).[15] The APRN Alliance[16], created in 1997,

[13] At its March 2006 meeting, the Alliance for Nursing Accreditation voted to change its name to the Alliance for APRN Credentialing which more accurately reflects its membership.

[14] The goal of the APRN Work Group was unanimous agreement on all issues and recommendations. However, this was recognized as an unrealistic expectation and may delay the process; therefore, consensus was defined as a two thirds majority agreement by those members of the Work Group present at the table as organizational representatives with each participating organization having one vote.

[15] The term advanced practice nurse (APN) was initially used by the Work Group and is used in this section of the report to accurately reflect the background discussion. However, the Work group reached consensus that the term advanced practice registered nurse (APRN) should be adopted for use in subsequent discussions and documents.

[16] Organizational members of the Alliance for APRN Credentialing : American Academy of Nurse Practitioners Certification Program, American Association of Colleges of Nursing, American Association of Critical-Care Nurses Certification Corporation, Council on Accreditation of Nurse Anesthesia Educational Programs, American College of Nurse-Midwives, American Nurses Credentialing Center, Association of Faculties of Pediatric Nurse Practitioners, Inc., Commission on Collegiate Nursing Education, National Association of Clinical Nurse Specialists, National Association of Nurse Practitioners in Women's Health, Council on Accreditation, Pediatric Nursing Certification Board, The National Certification Corporation for the Obstetric

was convened by AACN to regularly discuss issues related to nursing education, practice, and credentialing. A number of differing views on how APN practice is defined, what constitutes specialization versus subspecialization, and the appropriate credentialing requirements that would authorize practice had emerged over the past several years.

An invitation to participate in a national APN Consensus Process was sent to 50 organizations that were identified as having an interest in advanced practice nursing (see Appendix E). Thirty-two organizations participated in the APN Consensus Conference in Washington, DC June 2004 (See Appendix F). The focus of the one-day meeting was to initiate an in-depth examination of issues related to APN definition, specialization, sub-specialization, and regulation, which includes accreditation, education, certification and licensure[17]. Based on recommendations generated in the June 2004 APN Consensus Conference, the Alliance formed a smaller work group made up of designees from 23 organizations with broad representation of APN certification, licensure, education, accreditation, and practice. The charge to the work group was to develop a statement that addresses the issues, delineated during the APN Consensus Conference with the goal of envisioning a future model for APNs. The Alliance APN Consensus Work Group (hereafter referred to as "the Work Group") convened for sixteen days of intensive discussion between October 2004 and July 2007. (See Appendix G for a list of organizations represented on the APN Work Group.)

In December 2004, the American Nurses Association (ANA) and the American Association of Colleges of Nursing (AACN) co-hosted an APN stakeholder meeting to address those issues identified at the June 2004 APN Consensus meeting. Attendees agreed to ask the APN Work Group to continue to craft a consensus statement that would include recommendations regarding APN regulation, specialization and subspecialization. It also was agreed that organizations in attendance who had not participated in the June 2004 APN Consensus meeting would be included in the APN Consensus Group and that this larger group would reconvene at a future date to discuss the recommendations of the APN Work Group.

Following the December 2004 APN Consensus meeting, the Work Group continued to work diligently to reach consensus on the issues surrounding APRN education, practice, accreditation, certification and licensure, and to create a future consensus-based model for APRN regulation. Subsequent APRN Consensus Group meetings were held in September 2005, and June 2006. All organizations who participated in the APRN Consensus Group are listed in Appendix H.

APRN Joint Dialogue Group

In April, 2006, the APRN Advisory Panel met with the APRN Consensus Work Group to discuss APRN issues described in the NCSBN draft Vision Paper. The APRN Consensus

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Gynecologic and Neonatal Nursing Specialties, National Council of State Boards of Nursing, National Organization of Nurse Practitioner Faculties

[17] The term regulation refers to the four prongs of regulation: licensure, accreditation, certification and education.

Work Group requested and was provided with feedback from the APRN Advisory Panel regarding the APRN Consensus Group Report. Both groups agreed to continue to dialogue.

As the APRN Advisory Panel and APRN Consensus Work Group continued their work in parallel fashion, concerns regarding the need for each group's work not to conflict with the other were expressed. A subgroup of seven people from the APRN Consensus Work Group and seven individuals from the APRN Advisory Panel were convened in January, 2007. The group called itself the APRN Joint Dialogue Group (see Appendix E) and the agenda consisted of discussing areas of agreement and disagreement between the two groups. The goal of the subgroup meetings was anticipated to be two papers that did not conflict, but rather complemented each other. However, as the APRN Joint Dialogue Group continued to meet, much progress was made regarding areas of agreement; it was determined that rather than two papers being disseminated, one joint paper would be developed which reflected the work of both groups. This document is the product of the work of the APRN Joint Dialogue Group and through the consensus-based work of the APRN Consensus Work Group and the NCSBN APRN Advisory Committee.

Assumptions Underlying the Work of the Joint Dialogue Group

The consensus-based recommendations that have emerged from the extensive dialogue and consensus-based processes delineated in this report are based on the following assumptions:

- Recommendations must address current issues facing the advanced practice registered nurse (APRN) community but should be future oriented.
- The ultimate goal of licensure, accreditation, certification and education is to promote patient safety and public protection.
- The recognition that this document was developed with the participation of APRN certifiers, accreditors, public regulators, educators, and employers. The intention is that the document will allow for informed decisions made by each of these entities as they address APRN issues.

CONCLUSION

The recommendations offered in this paper present an APRN regulatory model as a collaborative effort among APRN educators, accreditors, certifiers and licensure bodies. The essential elements of APRN regulation are identified as licensure, accreditation, certification and education. The recommendations reflect a need and desire to collaborate among regulatory bodies to achieve a sound model and continued communication with the goal of increasing the clarity and uniformity of APRN regulation.

The goals of the consensus processes were to:

- Strive for harmony and common understanding in the APRN regulatory community that would continue to promote quality APRN education and practice;
- Develop a vision for APRN regulation, including education, accreditation, certification and licensure;
- Establish a set of standards that protect the public, improve mobility, and improve access to safe, quality APRN care; and

- Produce a written statement that reflects consensus on APRN regulatory issues.

In summary, this report defines the APRN Regulatory Model, including a definition of the Advanced Practice Registered Nurse; a definition of broad-based APRN education; a model for regulation that ensures APRN education and certification as a valid and reliable process, that is based on nationally recognized and accepted standards; uniform recommendations for licensing bodies across states; a process and characteristics for recognizing a new APRN role; and a definition of an APRN specialty that allows for the profession to meet future patient and nursing needs.

The work of the Joint Dialogue Group in conjunction with all organizations representing APRN licensure, accreditation, certification and education to advance a regulatory model is an ongoing collaborative process that is fluid and dynamic. As health care evolves and new standards and needs emerge the APRN Regulatory Model will advance accordingly to allow APRNs to care for patients in a safe environment to the full potential of their nursing knowledge and skill.

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APPENDIX A
NCSBN CRITERIA FOR EVALUATING CERTIFICATION PROGRAMS

Criteria	Elaboration
I. The program is national in the scope of its credentialing.	A. The advanced nursing practice category and standards of practice have been identified by national organizations. B. Credentialing services are available to nurses throughout the United States and its territories. C. There is a provision for public representation on the certification board. D. A nursing specialty organization that establishes standards for the nursing specialty exists. E. A tested body of knowledge related to the advanced practice nursing specialty exists. F. The certification board is an entity with organizational autonomy.
II. Conditions for taking the examination are consistent with acceptable standards of the testing community.	A. Applicants do not have to belong to an affiliated professional organization in order to apply for certification offered by the certification program. B. Eligibility criteria rationally related to competence to practice safely. C. Published criteria are enforced. D. In compliance with the American Disabilities Act. E. Sample application(s) are available. 1) Certification requirements included 2) Application procedures include: • procedures for assuring match between education and clinical experience, and APRN specialty being certified, • procedures for validating information provided by candidate, • procedures for handling omissions and discrepancies 3) Professional staff responsible for credential review and admission decisions. 4) Examination should be administered frequently enough to be accessible but not so frequently as to over-expose items. F. Periodic review of eligibility criteria and application procedures to ensure that they are fair and equitable.
III. Educational requirements are consistent with the requirements of the advanced practice specialty.	A. Current U.S. registered nurse licensure is required. B. Graduation from a graduate advanced practice education program meets the following requirements: 1) Education program offered by an accredited college or university offers a graduate degree with a concentration in the advanced nursing practice specialty the individual is seeking 2) If post-masters certificate programs are offered, they must be offered through institutions meeting criteria B.1.

	3) Both direct and indirect clinical supervision must be congruent with current national specialty organizations and nursing accreditation guidelines 4) The curriculum includes, but is not limited to: • biological, behavioral, medical and nursing sciences relevant to practice as an APRN in the specified category; • legal, ethical and professional responsibilities of the APRN; and • supervised clinical practice relevant to the specialty of APRN 5) The curriculum meets the following criteria: • Curriculum is consistent with competencies of the specific areas of practice • Instructional track/major has a minimum of 500 supervised clinical hours overall • The supervised clinical experience is directly related to the knowledge and role of the specialty and category C. All individuals, without exception, seeking a national certification must complete a formal didactic and clinical advanced practice program meeting the above criteria.
IV. The standard methodologies used are acceptable to the testing community such as incumbent job analysis study, logical job analysis studies.	A. Exam content based on a job/task analysis. B. Job analysis studies are conducted at least every five years. C. The results of the job analysis study are published and available to the public. D. There is evidence of the content validity of the job analysis study.
V. The examination represents entry-level practice in the advanced nursing practice category.	A. Entry-level practice in the advanced practice specialty is described including the following: 1) Process 2) Frequency 3) Qualifications of the group making the determination 4) Geographic representation 5) Professional or regulatory organizations involved in the reviews
VI. The examination represents the knowledge, skills and abilities essential for the delivery of safe and effective advanced nursing care to the clients.	A. The job analysis includes activities representing knowledge, skills and abilities necessary for competent performance. B. The examination reflects the results of the job analysis study. C. Knowledge, skills and abilities, which are critical to public safety, are identified. D. The examination content is oriented to educational curriculum practice requirements and accepted standards of care.
VII. Examination items are reviewed for content validity, cultural bias and correct scoring using an established mechanism, both before use and	A. Each item is associated with a single cell of the test plan. B. Items are reviewed for currency before each use at least every three years. C. Items are reviewed by members of under-represented gender and

periodically.	ethnicities who are active in the field being certified. Reviewers have been trained to distinguish irrelevant cultural dependencies from knowledge necessary to safe and effective practice. Process for identifying and processing flagged items is identified. D. A statistical bias analysis is performed on all items. E. All items are subjected to an "unscored" use for data collection purposes before their first use as a "scored" item. F. A process to detect and eliminate bias from the test is in place. G. Reuse guidelines for items on an exam form are identified. H. Item writing and review is done by qualified individuals who represent specialties, population subgroups, etc.
VIII. Examinations are evaluated for psychometric performance.	A. Reference groups used for comparative analysis are defined.
IX. The passing standard is established using acceptable psychometric methods, and is re-evaluated periodically.	A. Passing standard is criterion-referenced.
X. Examination security is maintained through established procedures.	A. Protocols are established to maintain security related to: 1) Item development (e.g., item writers and confidentiality, how often items are re-used) 2) Maintenance of question pool 3) Printing and production process 4) Storage and transportation of examination is secure 5) Administration of examination (e.g., who administers, who checks administrators) 6) Ancillary materials (e.g., test keys, scrap materials) 7) Scoring of examination 8) Occurrence of a crisis (e.g., exam is compromised, etc)
XI. Certification is issued based upon passing the examination and meeting all other certification requirements.	A. Certification process is described, including the following: 1) Criteria for certification decisions are identified 2) The verification that passing exam results and all other requirements are met 3) Procedures are in place for appealing decisions B. There is due process for situations such as nurses denied access to the examination or nurses who have had their certification revoked. C. A mechanism is in place for communicating with candidate. D. Confidentiality of nonpublic candidate data is maintained.
XII. A retake policy is in place.	A. Failing candidates permitted to be reexamined at a future date. B. Failing candidates informed of procedures for retakes. C. Test for repeating examinees should be equivalent to the test for first time candidates. D. Repeating examinees should be expected to meet the same test performance standards as first time examinees.

	E. Failing candidates are given information on content areas of deficiency. F. Repeating examinees are not exposed to the same items when taking the exam previously.
XIII. Certification maintenance program, which includes review of qualifications and continued competence, is in place.	A. Certification maintenance requirements are specified (e.g., continuing education, practice, examination, etc.). B. Certification maintenance procedures include: 1) Procedures for assuring match between continued competency measures and APRN specialty 2) Procedures for validating information provided by candidates 3) Procedures for issuing re-certification C. Professional staff oversee credential review. D. Certification maintenance is required a minimum of every 5 years.
XIV. Mechanisms are in place for communication to boards of nursing for timely verification of an individual's certification status, changes in certification status, and changes in the certification program, including qualifications, test plan and scope of practice.	A. Communication mechanisms address: 1) Permission obtained from candidates to share information regarding the certification process 2) Procedures to provide verification of certification to Boards of Nursing 3) Procedures for notifying Boards of Nursing regarding changes of certification status 4) Procedures for notification of changes in certification programs (qualifications, test plan or scope of practice) to Boards of Nursing
XV. An evaluation process is in place to provide quality assurance in its certification program.	A. Internal review panels are used to establish quality assurance procedures. 1) Composition of these groups (by title or area of expertise) is described 2) Procedures are reviewed 3) Frequency of review B. Procedures are in place to insure adherence to established QA policy and procedures.

Revised 11-6-01

APPENDIX B

American Nurses Association
Congress on Nursing Practice and Economics
2004

Recognition as a Nursing Specialty

The process of recognizing an area of practice as a nursing specialty allows the profession to formally identify subset areas of focused practice. A clear description of that nursing practice assists the larger community of nurses, healthcare consumers, and others to gain familiarity and understanding of the nursing specialty. Therefore, the document requesting ANA recognition must clearly and fully address each of the fourteen specialty recognition criteria. The inclusion of additional materials to support the discussion and promote understanding of the criteria is acceptable. A scope of practice statement must accompany the submission requesting recognition as a nursing specialty.

Criteria for Recognition as a Nursing Specialty

The following criteria are used by the Congress on Nursing Practice and Economics in the review and decision-making processes to recognize an area of practice as a nursing specialty:

A nursing specialty:

1. Defines itself as nursing.
2. Adheres to the overall licensure requirements of the profession.
3. Subscribes to the overall purposes and functions of nursing.
4. Is clearly defined.
5. Is practiced nationally or internationally.
6. Includes a substantial number of nurses who devote most of their practice to the specialty.
7. Can identify a need and demand for itself.
8. Has a well derived knowledge base particular to the practice of the nursing specialty.
9. Is concerned with phenomena of the discipline of nursing.
10. Defines competencies for the area of nursing specialty practice.
11. Has existing mechanisms for supporting, reviewing and disseminating research to support its knowledge base.

12. Has defined educational criteria for specialty preparation or graduate degree.

13. Has continuing education programs or continuing competence mechanisms for nurses in the specialty.

14. Is organized and represented by a national specialty association or branch of a parent organization.

APPENDIX C

NCBN APRN Committee Members 2003 -2008

2003
- Katherine Thomas, Executive Director, Texas Board of Nurse Examiners
- Patty Brown, Board Staff, Kansas State Board of Nursing
- Kim Powell, Board President, Montana Board of Nursing
- Charlene Hanson, Consultant
- Georgia Manning, Arkansas State Board of Nursing
- Deborah Bohannon-Johnson, Board President, North Dakota Board of Nursing
- Jane Garvin, Board President, Maryland Board of Nursing
- Janet Younger, Board President, Virginia Board of Nursing
- Nancy Chornick, NCSBN

2004
- Katherine Thomas, Executive Director, Texas Board of Nurse Examiners
- Patty Brown, Board Staff, Kansas State Board of Nursing
- Kim Powell, Board President, Montana Board of Nursing
- Charlene Hanson, Consultant
- Janet Younger, Board President, Virginia Board of Nursing
- Polly Johnson, Board Representative, North Carolina Board of Nursing
- Laura Poe, Member Utah State Board of Nursing
- Georgia Manning, Arkansas State Board of Nursing
- Jane Garvin RN, Board President, Maryland Board of Nursing
- Ann Forbes, Member Board Staff, North Carolina Board of Nursing
- Nancy Chornick, NCSBN

2005
- Katherine Thomas, Executive Director, Texas Board of Nurse Examiners
- Patty Brown, Board Staff, Kansas State Board of Nursing
- Charlene Hanson, Consultant
- Janet Younger, Board President, Virginia Board of Nursing
- Polly Johnson, Board Representative, North Carolina Board of Nursing
- Laura Poe, Member Utah State Board of Nursing
- Marcia Hobbs, Member Board Member, Kentucky Board of Nursing
- Randall Hudspeth, Member Board Member, Idaho Board of Nursing
- Ann Forbes, Member Board Staff, North Carolina Board of Nursing
- Cristiana Rosa, Member Board Member, Rhode Island Board of Nurse
- Kim Powell, Board President, Montana Board of Nursing
- Nancy Chornick, NCSBN

2006
- Katherine Thomas, Executive Director, Texas Board of Nurse Examiners
- Patty Brown, Board Staff, Kansas State Board of Nursing
- Charlene Hanson, Consultant
- Janet Younger, Board President, Virginia Board of Nursing
- Laura Poe, Member Utah State Board of Nursing
- Marcia Hobbs, Member Board Member, Kentucky Board of Nursing
- Randall Hudspeth, Member Board Member, Idaho Board of Nursing
- Cristiana Rosa, Member Board Member, Rhode Island Board of Nurse

- James Luther Raper, Board Member, Alabama Board of Nursing
- Linda Rice, Board Member, Vermont
- Cathy Williamson, Member Board Member, Mississippi Board of Nursing
- Ann Forbes, Member Board Staff, North Carolina Board of Nursing
- Polly Johnson, Board Representative, North Carolina Board of Nursing
- Sheila N. Kaiser, Member Board Vice-Chair, Massachusetts Board of Registration in Nursing
- Nancy Chornick, NCSBN

2007

- Faith Fields, Board Liaison Arkansas State Board of Nursing
- Katherine Thomas, Executive Director, Texas Board of Nurse Examiners
- Ann L. O'Sullivan, Board Member, Pennsylvania Board of Nursing
- Patty Brown, Board Staff, Kansas State Board of Nursing
- Charlene Hanson, Consultant
- Laura Poe, Member Utah State Board of Nursing
- John C. Preston, Board Member, Tennessee Board of Nursing
- Randall Hudspeth, Member Board Member, Idaho Board of Nursing
- Cristiana Rosa, Member Board Member, Rhode Island Board of Nurse
- James Luther Raper, Board Member, Alabama Board of Nursing
- Linda Rice, Board Member, Vermont
- Cathy Williamson, Member Board Member, Mississippi Board of Nursing
- Janet Younger, Board President, Virginia Board of Nursing
- Marcia Hobbs, Member Board Member, Kentucky Board of Nursing
- Nancy Chornick, NCSBN

2008

- Doreen K. Begley, Board Representative, Member Board Member, Nevada State Board of Nursing
- Ann L. O'Sullivan, Board Member, Pennsylvania Board of Nursing
- Patty Brown, Board Staff, Kansas State Board of Nursing
- Charlene Hanson, Consultant
- Laura Poe, Member Utah State Board of Nursing
- John C. Preston, Board Member, Tennessee Board of Nursing
- Randall Hudspeth, Member Board Member, Idaho Board of Nursing
- Cristiana Rosa, Member Board Member, Rhode Island Board of Nurse
- James Luther Raper, Board Member, Alabama Board of Nursing
- Linda Rice, Board Member, Vermont
- Cathy Williamson, Member Board Member, Mississippi Board of Nursing
- Tracy Klein, Member Staff, Oregon State Board of Nursing
- Darlene Byrd, Member Board Member, Arkansas State Board of Nursing
- Nancy Chornick, NCSBN

Appendix D

2006 NCSBN APRN Roundtable
Organization Attendance List

Alabama Board of Nursing
American Academy of Nurse Practitioners
American Academy of Nurse Practitioners National Certification Program, Inc
American Association of Colleges of Nursing
American Association of Critical-Care Nurses
American Association of Nurse Anesthetists
American Association of Psychiatric Nurses
American Board of Nursing Specialties
American College of Nurse Practitioners
American College of Nurse-Midwives
American Holistic Nurses' Certification Corporation
American Midwifery Certification Board
American Nurses Association
American Nurses Credentialing Center
American Organization of Nurses Executives
Association of Women's Health, Obstetric and Neonatal Nurses
Board of Certification for Emergency Nursing
Council on Accreditation of Nurse Anesthesia Educational Programs
Emergency Nurses Association
George Washington School of Medicine
Idaho Board of Nursing
Kansas Board of Nursing
Kentucky Board of Nursing
Massachusetts Board of Nursing
Mississippi Board of Nursing
National Association of Clinical Nurse Specialists
National Association of Nurse Practitioners in Women's Health
National Association of Pediatric Nurse Practitioners
National Board for Certification of Hospice & Palliative Nurses
National Certification Corporation for the Obstetric, Gynecologic and Neonatal Nursing Specialties
National League for Nursing Accrediting Commission
North Carolina Board of Nursing
Oncology Nursing Certification Corporation
Pediatric Nursing Certification Board
Rhode Island Board of Nursing

Texas Board of Nurse Examiners
Utah Board of Nursing
Vermont Board of Nursing
Wound, Ostomy and Continence Nursing Certification Board

2007 APRN Roundtable Attendance List

American Association of Colleges of Nursing
ABNS Accreditation Council
ACNM
Alabama Board of Nursing
American Academy of Nurse Practitioners
American Academy of Nurse Practitioners National Certification Program, Inc
American Association of Critical-Care Nurses
American Association of Nurse Anesthetists
American College of Nurse-Midwives
American College of Nurse Practitioners
American Midwifery Certification Board
American Nurses Credentialing Center - Certification Services
American Organization of Nurse Executives
ANCC Certifications
Arkansas State Board of Nursing
AWHONN
Board of Certification for Emergency Nursing
CCNE Board of Commissioners
Colorado Board of Nursing
Commission on Collegiate Nursing Education
Council on Accreditation of Nurse Anesthesia Educational Programs
Council on Certification of Nurse Anesthetists and Council on Recertification of Nurse Anesthetists
Emergency Nurses Association
Idaho Board of Nursing
Illinois State Board of Nursing
Kansas Board of Nursing
Kentucky Board of Nursing
Loyola University Chicago Niehoff School of Nursing
Minnesota Board of Nursing
Mississippi Board of Nursing
National Association of Clinical Nurse Specialists

NAPNAP
National League for Nursing Accrediting Commission
National Organization of Nurse Practitioner Faculties
NCC
Oncology Nursing Certification Corporation
Pennsylvania Board of Nursing
PNCB
Rhode Island Board of Nursing
Rush University College of Nursing
South Dakota Board of Nursing
Tennessee Board of Nursing
Texas Board of Nurse Examiners
Vermont Board of Nursing

APPENDIX E

APRN Joint Dialogue Group
Organizations represented at the Joint Dialogue Group Meetings

American Academy of Nurse Practitioners Certification Program
American Association of Colleges of Nursing
American Association of Nurse Anesthetists
American College of Nurse-Midwives
American Nurses Association
American Organization of Nurse Executives
Compact Administrators
National Association of Clinical Nurse Specialists
National League for Nursing Accrediting Commission
National Organization of Nurse Practitioner Faculties
National Council of State Boards of Nursing
NCSBN APRN Advisory Committee Representatives (5)

Appendix F

ORGANIZATIONS INVITED TO APN CONSENSUS CONFERENCE JUNE, 2004

American Academy of Nurse Practitioners
American Academy of Nurse Practitioners Certification Program
American Academy of Nursing
American Association of Critical Care Nurses
American Association of Critical Care Nurses Certification Program
American Association of Nurse Anesthetists
American Association of Occupational Health Nurses
American Board of Nursing Specialties
American College of Nurse Practitioners
American College of Nurse-Midwives
American College of Nurse-Midwives Division of Accreditation
American Nurses Association
American Nurses Credentialing Center
American Organization of Nurse Executives
American Psychiatric Nurses Association
Association of Faculties of Pediatric Nurse Practitioners
Association of Rehabilitation Nurses
Association of Women's Health, Obstetric and Neonatal Nurses
Certification Board Perioperative Nursing
Commission on Collegiate Nursing Education
Council on Accreditation of Nurse Anesthesia Educational Programs
Division of Nursing, DHHS, HRSA
Emergency Nurses Association
Hospice and Palliative Nurses Association
International Nurses Society on Addictions
International Society of Psychiatric-Mental Health Nurses
NANDA International
National Association of Clinical Nurse Specialists
National Association of Neonatal Nurses
National Association of Nurse Practitioners in Women's Health
National Association of Nurse Practitioners in Women's Health, Council on Accreditation
National Association of Pediatric Nurse Practitioners
National Association of School Nurses
National Board for Certification of Hospice and Palliative Nurses
National Certification Corporation for the Obstetric, Gynecologic and Neonatal Nursing Specialties
National Conference of Gerontological Nurse Practitioners
National Council of State Boards of Nursing
National Gerontological Nursing Association
National League for Nursing
National League for Nursing Accrediting Commission

National Organization of Nurse Practitioner Faculties
Nurse Licensure Compact Administrators/State of Utah Department of Commerce/Division of Occupational & Professional Licensing
Nurses Organization of Veterans Affairs
Oncology Nursing Certification Corporation
Oncology Nursing Society
Pediatric Nursing Certification Board
Sigma Theta Tau, International
Society of Pediatric Nurses
Wound Ostomy & Continence Nurses Society
Wound Ostomy Continence Nursing Certification Board

APPENDIX G

ORGANIZATIONS PARTICIPATING IN APRN CONSENSUS PROCESS

Academy of Medical-Surgical Nurses
American College of Nurse-midwives Division of Accreditation
American Academy of Nurse Practitioners
American Academy of Nurse Practitioners Certification Program
American Association of Colleges of Nursing
American Association of Critical Care Nurses Certification
American Association of Neuroscience Nurses
American Association of Nurse Anesthetists
American Association of Occupational Health Nurses
American Board for Occupational Health Nurses
American Board of Nursing Specialties
American College of Nurse-Midwives
American College of Nurse-Midwives Division of Accreditation
American College of Nurse Practitioners
American Holistic Nurses Association
American Nephrology Nurses Association
American Nurses Association
American Nurses Credentialing Center
American Organization of Nurse Executives
American Psychiatric Nurses Association
American Society of PeriAnesthesia Nurses
American Society for Pain Management Nursing
Association of Community Health Nursing Educators
Association of Faculties of Pediatric Nurse Practitioners
Association of Nurses in AIDS Care
Association of PeriOperative Registered Nurses
Association of Rehabilitation Nurses
Association of State and Territorial Directors of nursing
Association of Women's Health, Obstetric and Neonatal Nurses
Board of Certification for Emergency Nursing
Council on Accreditation of Nurse Anesthesia Educational Programs
Commission on Collegiate Nursing Education
Commission on Graduates of Foreign Nursing Schools
District of Columbia Board of Nursing
Department of Health
Dermatology Nurses Association
Division of Nursing, DHHS, HRSA
Emergency Nurses Association
George Washington University
Health Resources and Services Administration
Infusion Nurses Society
International Nurses Society on Addictions

International Society of Psychiatric-Mental Health Nurses
Kentucky Board of Nursing
National Association of Clinical Nurse Specialists
National Association of Neonatal Nurses
National Association of Nurse Practitioners in Women's Health, Council on Accreditation
National Association of Pediatric Nurse Practitioners
National Association of School of Nurses
National Association of Orthopedic Nurses
National Certification Corporation for the Obstetric, Gynecologic, and Neonatal Nursing Specialties
National Conference of Gerontological Nurse Practitioners
National Council of State Boards of Nursing
National League for Nursing
National League for Nursing Accrediting Commission
National Organization of Nurse Practitioner Faculties
Nephrology Nursing Certification Commission
North American Nursing Diagnosis Association International
Nurses Organization of Veterans Affairs
Oncology Nursing Certification Corporation
Oncology Nursing Society
Pediatric Nursing Certification Board
Pennsylvania State Board of Nursing
Public Health Nursing Section of the American Public Health Association.
Rehabilitation Nursing Certification Board
Society for Vascular Nursing
Texas Nurses Association
Texas State Board of Nursing
Utah State Board of Nursing
Women's Health, Obstetric & Neonatal Nurses
Wound, Ostomy, & Continence Nurses Society
Wound, Ostomy, & Continence Nursing Certification

APPENDIX H

APRN CONSENSUS PROCESS WORK GROUP

ORGANIZATIONS THAT WERE REPRESENTED AT THE WORK GROUP MEETINGS

Jan Towers, American Academy of Nurse Practitioners Certification Program
Joan Stanley, American Association of Colleges of Nursing
Carol Hartigan, American Association of Critical Care Nurses Certification Corporation
Leo LeBel, American Association of Nurse Anesthetists
Bonnie Niebuhr, American Board of Nursing Specialties
Peter Johnson & Elaine Germano, American College of Nurse-Midwives
Mary Jean Schumann, American Nurses Association
Mary Smolenski, American Nurses Credentialing Center
M.T. Meadows, American Organization of Nurse Executives
Edna Hamera & Sandra Talley, American Psychiatric Nurses Association
Elizabeth Hawkins-Walsh, Association of Faculties of Pediatric Nurse Practitioners
Jennifer Butlin, Commission on Collegiate Nursing Education
Laura Poe, APRN Compact Administrators
Betty Horton, Council on Accreditation of Nurse Anesthesia Educational Programs
Kelly Goudreau, National Association of Clinical Nurse Specialists
Fran Way, National Association of Nurse Practitioners in Women's Health, Council on Accreditation
Mimi Bennett, National Certification Corporation for the Obstetric, Gynecologic, and Neonatal Nursing Specialties
Kathy Apple, National Council of State Boards of Nursing
Grace Newsome & Sharon Tanner, National League for Nursing Accrediting Commission
Kitty Werner & Ann O'Sullivan, National Organization of Nurse Practitioner Faculties
Cyndi Miller-Murphy, Oncology Nursing Certification Corporation
Janet Wyatt, Pediatric Nursing Certification Board
Carol Calianno, Wound, Ostomy and Continence Nursing Certification Board
Irene Sandvold, DHHS, HRSA, Division of Nursing *(observer)*

ADDENDUM

Example of a National Consensus-Building Process to Develop Nationally Recognized Education Standards and Role/Specialty Competencies

The national consensus-based process described here was originally designed, with funding by the Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, Division of Nursing, to develop and validate national consensus-based primary care nurse practitioner competencies in five specialty areas. The process was developed with consultation from a nationally recognized expert in higher education assessment. The process subsequently has been used and validated for the development of similar sets of competencies for other areas of nursing practice, including competencies for mass casualty education for all nurses and competencies for acute care nurse practitioners and psych/mental health nurse practitioners.

This process for developing nationally recognized educational standards, nationally recognized role competencies and nationally recognized specialty competencies is an iterative, step-wise process. The steps are:
Step 1: At the request of the organization(s) representing the role or specialty, a neutral group or groups convenes and facilitates a national panel of all stakeholder organizations as defined in step 2.
Step 2: To ensure broad representation, invitations to participate should be extended to one representative of each of the recognized nursing accrediting organizations, certifiers within the role and specialty, groups whose primary mission is graduate education and who have established educational criteria for the identified role and specialty, and groups with competencies and standards for education programs that prepare individuals in the role and specialty.
Step 3: Organizational representatives serving on the national consensus panel bring and share role delineation studies, competencies for practice and education, scopes and standards of practice, and standards for education programs.
Step 4: Agreement is reached among the panel members
Step 5: Panel members take the draft to their individual boards for feedback.
Step 6: That feedback is returned to the panel. This is an iterative process until agreement is reached.
Step 7: Validation is sought from a larger group of stakeholders including organizations and individuals. This is known as the Validation Panel.
Step 8: Feedback from the Validation Panel is returned to National Panel to prepare the final document.
Step 9: Final document is sent to boards represented on the National Panel and the Validation Panel for endorsement.

The final document demonstrates national consensus through consideration of broad input from key stakeholders. The document is then widely disseminated.

BOARD OF REGISTERED NURSING
Nursing Practice
Agenda Item Summary

AGENDA ITEM: 11.3
DATE: February 20, 2009

ACTION REQUESTED:	Legislation Enacted During the 2007-2008 Session, Information AB 211 (Jones) Chapter 602: Public Health: Confidential Medical Information
REQUESTED BY:	Janette Wackerly, MBA, RN Nursing Education Consultant

BACKGROUND:
AB 211 (Jones) Chapter 602 Public Health Confidential Medical Information requires every provider of health care to implement appropriate specific safeguards to protect the privacy of patient medical information. Any licensed health care professional who knowingly, willfully obtains, discloses, or violates the use of medical information can be fined. This new law permits the director to send a recommendation for further investigation, or discipline for a potential violation, to the licensee's licensing authority. The law requires every provider of health care to establish and implement appropriate administrative, technical, and physical safeguards to protect the privacy of a patient's medical record.

NEXT STEP:	Place on Board Agenda.
FINANCIAL IMPLICATIONS, IF ANY:	None
PERSON TO CONTACT:	Janette Wackerly, MBA, RN Nursing Education Consultant (916) 574-7686

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

STATE AND CONSUMER SERVICES AGENCY • ARNOLD SCHWARZENEGGER, GOVERNOR

BOARD OF REGISTERED NURSING
P.O Box 944210, Sacramento, CA 94244-2100
P (916) 322-3350 | www.rn.ca.gov

Ruth Ann Terry, MPH, RN, Executive Officer

Public Health
Confidential Medical Information

Law enacted in the 2007-2008 Legislative Session

AB 211 (Jones) Chapter 602 Public Health requires every provider of health care to implement appropriate specified safeguards to protect the privacy of patient medical information. This law requires every provider of health care to reasonably safeguard confidential medical information from unauthorized or unlawful access, use, or disclosure. The law establishes within the California Health and Human Services Agency the office of Health Information Integrity to assess and impose administrative fines for a violation of these provisions. The office has the authority to impose administrative fines for the unauthorized use of medical information. Any licensed health care professional, who knowing and willfully obtains, discloses, or violates the use of medical information would be fined as follows:

- First violation--$5000 per violation
- Second violation--$25,000 per violation
- Third violation--$250,000 per violation

This new law will permit the director to send a recommendation for further investigation, or discipline for a potential violation, to the licensee's licensing authority.

The law requires every provider of health care to establish and implement appropriate administrative, technical, and physical safeguards to protect the privacy of a patient's medical record.

BOARD OF REGISTERED NURSING
Nursing Practice
Agenda Item Summary

AGENDA ITEM: 11.4
DATE: February 20, 2009

ACTION REQUESTED: Information and Discussion: Gov. Schwarzenegger Signs Legislation to Protect Patients and Prevent Deadly Hospital Infections:

a. SB 1058 (Alquist) Chapter 296 Medical Facility Infection Control and Prevention Act or Nile's Law.
b. SB 158 (Flores) Chapter 294: Dept of Public Health (CDPH) Healthcare Associated Infection Advisory Committee
c. SB 891 (Correa) Chapter 295: Establishes Elective Percutaneous Coronary Intervention Pilot Program at CDPH (off agenda)

REQUESTED BY: Janette Wackerly, MBA, RN
Nursing Education Consultant

BACKGROUND:
The board's NEC staff has received numerous calls from hospital based infection control RNs and Performance Improvement RNs asking whether Standardized Procedures, policies and protocols, can be utilized to implement some requirements for infection surveillance functions.

The nurses are questioning whether Standardized Procedures can be utilized due to CMS interpretations of Medicare and Medicaid Conditions of Participation and refer to MAC ALERT. For your review are MAC ALERT February 10, 2008 and October 26, 2008 related to "Standing Orders". See attached

Attachments:
Senate Bill 1508 by Sen. Elaine Alquist will require hospitals to publicly disclose their infection rates and screen certain high risk patients for MRSA. Sen. Alquist as reported was particularly moved by a meeting she had with parents of Nile Moss, an Orange County teenager who died from a MRSA infection after a visit to a hospital where he had a MRI. Thus, Nile's Law or Medical Facility Infection Control and Prevention Act. SB 1058 will require hospitals to report infections such as MRSA to Dept of Health Services, effective January 1, 2009. The information will be made available to the public through the department's Website beginning in 2011. Screening of at-risk patients for MRSA will begin with January 1, 2009, these patients will be screened prior to discharge to determine whether they were infected while in the hospital.

Senate Bill 158 by Sen Flores gives the Department of Health Services additional authority to investigate infection outbreaks and complaints about lax infection control practices. This bill require hospitals to provide continuing education and training for workers, including conducting hand-washing campaigns.

SB 891 (Correa) Chapter 295: Establishes Elective Percutaneous Coronary Intervention Pilot Program Committee.

Business and Professions Code § 2725 including (c) standardized procedures, policies and protocols, developed through collaboration amongst administrators and health professionals, including physicians and nurses by an organized health care system licensed pursuant to Health And Safety Code 1250. California Code of Regulation § 1470 Standardized Procedure Guidelines states the purpose of these guideline is to:

(a) To protect consumers by providing evidence the nurse meets all requirements to practice safely.
(b) To provide uniformity in development of standardized procedures.

NEXT STEP: Place on Board Agenda.

FINANCIAL IMPLICATIONS, IF ANY: None

PERSON TO CONTACT: Janette Wackerly, MBA, RN
Nursing Education Consultant
(916) 574-7686

MAC ALERT

Brought to you as a service by the Center for Improvement in Healthcare Quality
Maintaining Accreditation Compliance Program

Date: February 10, 2008

Subject: CMS Issues Guidance to State Agencies on Prescribing of Medications

Applicability: (checked box means the subject applies to the JCAHO accreditation manual (or CMS type) cited)

✓ Acute Care	✓ Critical Access	☐ Long Term Care	☐ Home Health / Hospice
☐ Behavioral Health	☐ Laboratory	☐ Ambulatory Care	☐ Other: _____

Background:
In a letter dated 2/8/08, CMS issued guidance to state enforcement agencies on minimum requirements regarding the prescribing of medications. The guidance reinforced CMS interpretive guidelines addressing CFR *§482.23(c)(2)*. Specifically, the guidance reiterated CMS position that:

1. *"All orders for drugs and biologicals, with the exception of influenza and pneumococcal polysaccharide vaccines, must be documented and signed by a practitioner who is authorized by hospital policy, and in accordance with State law, to write orders and who is responsible for the care of the patient as specified under §482.12(c).*

2. *Nurse Practitioners and Physician Assistants responsible for the care of specific patients are also permitted to order drugs and biologicals in accordance with delegation agreements, collaborative practice agreements, hospital policy and State law.*

3. *Influenza and pneumococcal polysaccharide vaccines may be administered per physician-approved hospital policy after an assessment of contraindications.*

4. *If a hospital uses other written protocols or standing orders for drugs or biologicals that have been reviewed and approved by the medical staff, initiation of such protocols or standing orders requires an order from a practitioner responsible for the patient's care".*

Discussion:
In the guidance letter, CMS clarifies and reinforces its interpretation of an issue that has caused significant confusion in the industry – namely the use of "standing orders". It has become common practice for hospitals to develop protocols and other "standing orders" addressing a variety of situations. Common examples include protocols in Emergency Departments to treat simple issues such as infant fever, or more complex issues such as chest pain. Other examples include standing orders to admit patients to newborn nursery.

In many of these situations, staff' implement these protocols or standing orders without actually obtaining an order from an authorized practitioner under the mistaken belief that this is permitted since the protocol or standing order was approved by the medical staff. This is directly at odds with CMS requirements that such protocols or standing orders – even though approved by the medical staff – must be authorized by the practitioner prior to being initiated.

Recommendations:
CIHQ recommends the following:
1. This alert should be shared with appropriate clinical and administrative staff
2. Organizations should review their use of standing orders and protocols and amend practices so that they are in compliance with CMS.

--- END ---

MAC ALERT

Brought to you as a service by the Center for Improvement in Healthcare Quality
Maintaining Accreditation Compliance Program

Date: October 26, 2008

Subject: CMS CLARIFIES STANCE ON USE OF STANDING ORDERS & PROTOCOLS

Applicability: (checked box means the subject applies to the Joint Commission accreditation manual (or CMS type) cited)

✓ Acute Care	✓ Critical Access	☐ Long Term Care	☐ Home Health / Hospice
☐ Behavioral Health	☐ Laboratory	☐ Ambulatory Care	☐ Other: _____

Background:
In a letter to State enforcement agencies dated 10/24/08, CMS clarified its regulations requiring that standing orders and protocols containing medication be authorized by a physician before implementation.

In the letter, CMS stated: *"The use of standing orders must be documented as an order in the patient's medical record and authenticated by the practitioner responsible for the care of the patient, as the regulations at 42 CFR §482.23(c)(2) and §482.24(c)(1) require, but the timing of such documentation should not be a barrier to effective emergency response, timely and necessary care, or other patient safety advances. We would expect to see that the standing order had been entered into the order entry section of the patient's medical record as soon as possible after implementation of the order (much like a verbal order would be entered), with authentication by the patient's physician."*

CMS went on to state that it "*strongly supports the use of evidence-based protocols to enhance the quality of care provided to hospital patients. Many hospitals employ such protocols developed by physicians and other clinical staff that are designed to standardize and optimize patient care in accordance with current clinical guidelines or standards of practice."*

Finally, CMS acknowledged that "*While there is significant merit to the use of standing orders, there is also the potential for harm to patients if hospitals use such orders so that nurses or other clinical staff' are routinely expected to make clinical decisions outside their scope of practice. This is a complex issue which requires careful consideration by hospitals, physicians, nurses and other licensed health care professionals, experts in patient safety and quality improvement, and patients.*

Discussion:
The clarification by CMS is in response to an industry-wide outcry over the unrealistic and overly stringent initial revision to the interpretive guidelines.

This new interpretive guidelines by CMS essentially, allows medical staff approved standing orders and protocols containing medication to be implemented prior to receipt of a physician order. However, CMS does still expect that the order by authorized by a physician and entered into the medical record as soon as possible.

Recommendations:
CIHQ recommends the following:
1. This alert should be shared with appropriate clinical and administrative leadership as well as staff.
2. Policies and practices should be reviewed and revised as necessary to support this latest interpretation.

--- END ---

State of California—Health and Human Services Agency
California Department of Public Health

MARK B HORTON, MD, MSPH
Director

ARNOLD SCHWARZENEGGER
Governor

DRAFT

October 9, 2008 AFL 08-19

TO: GENERAL ACUTE CARE HOSPITALS

SUBJECT: **MANDATED REPORTING OF CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS**

DISTRIBUTION LIST –
Accrediting and Licensing

This is the **only** copy being sent to your facility. Please distribute copies to:
Chief Executive Officer
Chief Nurse Executive
Quality Management Department
Infection Control Committee Chair
Infection Preventionists

Authority:
Senate Bill (SB) 1058 (Alquist, Statues of 2008)
California Code of Regulations, Title 22, §70739

Attachments:
A.
B.

Background:
SB 1058 "Medical Facility Infection Control and Prevention Act" or "Nile's Law" was signed into law on September 25, 2008 and will become effective January 1, 2009. It requires the quarterly reporting of central line bloodstream infections and number of central line days to the California Department of Public Health.

Please review and share this document with all persons in your facility responsible for infection prevention and control activities and quality management reporting.

Division of Communicable Disease Control/Infectious Diseases Branch/Disease Investigations Section
850 Marina Bay Parkway, Building P 2nd Floor, Richmond, CA 94804
Ph: (510) 620-3434 Fax: (510) 620-3425
Internet Address: www.cdph.ca.gov

Mandated reporting of central line-associated bloodstream infections as defined by National Healthcare Safety Network (NHSN) is required to begin on January 1, 2009 in throughout your facility.

Options:

1. Facilities may report via the NHSN Primary Bloodstream Infection (BSI) module. This module can be accessed for reporting through the NHSN Secure Data Network or the form downloaded from the NHSN Members Page Document Library at http://www.cdc.gov/ncidod/dhqp/nhsn_PSforms.html. This mode of reporting is strongly suggested.

    - The BSI Module must be entered into the required monthly NHSN reporting plan and data entered according to NHSN rules.

    - This module requires the entry of denominator data in the form of central line days. A template of a data collection form can be found in the NHSN Document Library and is entitled "Denominators for Intensive Care Unit (ICU)/Other Locations, and "Denominators for Neonatal Intensive Care Unit (NICU)"

    - The facility is to confer rights for the CDPH Group to view the BSI module. The training webinar on how to confer rights to a group is located under Archived Training dated April 19, 2007. http://www.cdc.gov/ncidod/dhqp/nhsn_pastTraining.html

2. Facilities may transmit information to CDPH <use your imagination here>

For questions, the point of contact @ CDPH is Sue Chen, HAI Program Coordinator at Sue.Chen@cdph.ca.gov or phone (510) 620-3434.

Sincerely,

Kathleen Billingsley, RN
Deputy Director
Center for Healthcare Quality

Cc: California Hospital Association
California Conference of Local Health Officers
CDPH Emergency Preparedness Office
CDPH Licensing and Certification Program
CDPH Division of Communicable Disease Control
HAI Advisory Committee

THE SACRAMENTO BEE sacbee.com

This story is taken from Sacbee / Capitol and California

State's hospitals must come clean on germs

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Second in a series of new state laws that take effect Jan. 1.

On her second night home after giving birth by Caesarean section to her fourth child, Cindy Gaston's incision burst open and pus began oozing out.

Doctors at Mercy San Juan Medical Center in Carmichael, where she had given birth, later determined she was infected with methicillin-resistant staph aureus, or MRSA.

The strain of a once-innocuous staph infection that has become invulnerable to first-line antibiotics kills more people each year than the AIDS virus and in most cases is contracted in hospitals.

Beginning Thursday, legislation will be phased in requiring all 400 hospitals in the state to implement tougher infection control practices to stem outbreaks.

"I had never even heard of MRSA or that there was a risk of becoming infected with it in a hospital," said Gaston, who lives in Elverta.

The federal centers for Disease Control and Prevention estimates 2 million patients contract an infection in hospitals every year and nearly 100,000 of them die. As many as 9,600 of those deaths occur in California, according to the state Department of Health Services.

Senate Bill 1058 by Sen. Elaine Alquist, D-Santa Clara, will require hospitals to publicly disclose their infection rates and screen certain high-risk patients for MRSA.

"The heartbreaking thing is this is something than can be prevented with something as simple as hand-washing," Alquist said. "Hospitals ought to be safe places to go – you shouldn't go in and then die from something else."

Senate Bill 158 by Sen. Dean Florez, D-Shafter, gives the Department of Health Services additional authority to investigate infection outbreaks and complaints about lax infection control practices.

"These important measures will help save lives and health care dollars by reducing the number of infections that people are exposed to while staying in the hospital," Gov. Arnold Schwarzenegger declared when he signed the bills.

Alquist was particularly moved by a meeting she had with the parents of Nile Moss, an Orange County teenager who died from a MRSA infection after a visit to the hospital where he got an MRI.

Even the famous are not immune. Tom Brady, quarterback for the three-time Super Bowl champion New England Patriots, contracted a serious infection after undergoing knee surgery at a Southern California hospital. Brady required a second surgery to clean out the infection.

One of the driving forces behind the legislation was Consumers Union, publisher of Consumer Reports. Betsy Imholz, director of special projects for Consumers Union, said 20 states have passed public disclosure laws.

Imholz said that until this year, hospitals in California had resisted similar efforts, citing costs.

"I think what really pushed us over this time was years of hard work," Imholz said. "We also had thousands of individuals like Cindy who've been personally affected and learned to walk the halls (of the Capitol), testified at hearings and sent thousands of e-mails."

Debby Rogers, vice president of quality and emergency services for the California Hospital Association, said there's "a misperception that we were resistant."

"We worked very hard with (Alquist) and the constituent groups to try to craft a workable bill," Rogers said.

She said hospitals will incur added costs to collect infection data and screen for MRSA.

"This will be challenge in an environment where there are shrinking health care dollars, we have the lowest Medi-Cal reimbursement rates and hospitals prioritize where they're going to spend resources," she said.

Rogers said hospitals in the state have been working "very hard" to curtail infections. But some cases are inevitable, she said.

"Hospitals are places where sick people go, where immunocompromised patients go – so they're more predisposed to infections," she said.

According to supporters of the legislation, hospital infections add a staggering $3 billion to health care bills in California each year.

Beth Capell, a health care lobbyist, said the legislation was bolstered by a "growing recognition by many employers that hospital-acquired infections and other preventable conditions are increasing health care costs."

Preventing MRSA infections in hospitals can be as simple as conscientious hand-washing, isolating infected patients and using disposable gowns and gloves in their rooms.

Some hospitals do a better job than others at stopping them. But according to the National Quality Forum, hand-washing compliance rates at hospitals are generally less than 50 percent.

SB 1058 will require hospitals to report infections such as MRSA to the Department of Health Services, effective Jan. 1. The information will be made available to the public through the department's Web site beginning in 2011.

Screening of at-risk patients for MRSA will begin with the new year. Beginning in 2011, these patients will be screened prior to discharge to determine whether they were infected while in the hospital.

SB 158 will require hospitals to provide continuing education and training for workers, including conducting hand-washing campaigns.

Gaston, who required three surgeries to clean out her infection, was surprised by the sometime poor infection control practices she observed during her hospital stays.

While her visitors were required to put on disposable gowns, hospital workers who brought in her food and cleaned her room did not put on the gowns.

"People should not have to endure these kind of infections, especially from a place where they went to get well," she said. "My hope is this legislation will prevent a lot people from having to suffer like I did."

Call Aurelio Rojas, Bee Capitol Bureau, (916) 326-5545.

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BILL TEXT

CHAPTER 296
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AMENDED IN SENATE APRIL 15, 2008
AMENDED IN SENATE MARCH 26, 2008
AMENDED IN SENATE FEBRUARY 25, 2008

INTRODUCED BY Senator Alquist

JANUARY 7, 2008

An act to add Sections 1255.8 and 1288.55 to the Health and Safety Code, relating to health.

LEGISLATIVE COUNSEL'S DIGEST

SB 1058, Alquist. Health facilities: bacterial infections.

Existing law provides for the licensure and regulation of health facilities by the State Department of Public Health. A violation of these provisions is a crime.

This bill would establish the Medical Facility Infection Control and Prevention Act or Nile's Law, which would require general acute care hospitals to implement certain procedures for the screening, prevention, and reporting of specified health-care-associated infections. This bill would require the department to carry out certain duties in order to implement the bill. Because a violation of the health facility provisions is a crime, the bill would impose a state-mandated local program.

This bill would require health facilities to report to the department and the federal Centers for Disease Control and Prevention, specified infections. This bill would require the department to develop and implement various Internet-based reporting systems, as prescribed.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. The Legislature finds and declares all of the following:

(a) (1) The protection of patients in California health facilities is of paramount importance to the citizens of this state.

(2) During the past two decades health-care-associated infections,

especially those that are resistant to commonly used antibiotics, have increased dramatically.

(3) The State Department of Public Health needs to develop a better, more efficient system to monitor and report the incidence of antibiotic-resistant and other organisms causing infection that are acquired by patients in health facilities.

(4) The department needs to establish and maintain a comprehensive inspection and reporting system for health facilities that will ensure that those facilities comply with state laws and regulations designed to reduce the incidence of health-care-associated infections.

(b) It is, therefore, the intent of the Legislature to enact legislation that will do all of the following:

(1) Ensure that California's standards for protecting patients from exposure to pathogens in health facilities, including Methicillin-resistant Staphylococcus aureus (MRSA), are adequate to reduce the incidence of antibiotic-resistant organisms causing infection acquired by patients in these facilities.

(2) Ensure that the department develops and implements an Internet-based public reporting system that provides updated information regarding the incidence of infections, including associated pathogens acquired in health facilities, as well as the number of infection control personnel relative to the number of licensed beds.

(3) Ensure that health facilities implement improved procedures intended to maintain sanitary standards in these facilities, reduce transmission of pathogens that cause infection, and provide adequate training to health care professionals regarding the prevention and treatment of health-care-associated MRSA and other health-care-associated infections in these facilities.

SEC. 2. This act shall be known, and may be cited, as the Medical Facility Infection Control and Prevention Act or Nile's Law.

SEC. 3. Section 1255.8 is added to the Health and Safety Code, to read:

1255.8. (a) For purposes of this section, the following terms have the following meanings:

(1) "Colonized" means that a pathogen is present on the patient's body, but is not causing any signs or symptoms of an infection.

(2) "Committee" means the Healthcare Associated Infection Advisory Committee established pursuant to Section 1288.5.

(3) "Health facility" means a facility as defined in subdivision (a) of Section 1250.

(4) "Health-care-associated infection," "health-facility-acquired infection," or "HAI" means a health-care-associated infection as defined by the National Healthcare Safety Network of the federal Centers for Disease Control and Prevention, unless the department adopts a definition consistent with the recommendations of the committee or its successor.

(5) "MRSA" means Methicillin-resistant Staphylococcus aureus.

(b) (1) Each patient who is admitted to a health facility shall be tested for MRSA in the following cases, within 24 hours of admission:

(A) The patient is scheduled for inpatient surgery and has a documented medical condition making the patient susceptible to infection, based either upon federal Centers for Disease Control and Prevention findings or the recommendations of the committee or its successor.

(B) It has been documented that the patient has been previously discharged from a general acute care hospital within 30 days prior to the current hospital admission.

(C) The patient will be admitted to an intensive care unit or burn unit of the hospital.

(D) The patient receives inpatient dialysis treatment.

(E) The patient is being transferred from a skilled nursing facility.

(2) The department may interpret this subdivision to take into account the recommendations of the federal Centers for Disease Control and Prevention, or recommendations of the committee or its successor.

(3) If a patient tests positive for MRSA, the attending physician shall inform the patient or the patient's representative immediately or as soon as practically possible.

(4) A patient who tests positive for MRSA infection shall, prior to discharge, receive oral and written instruction regarding aftercare and precautions to prevent the spread of the infection to others.

(c) Commencing January 1, 2011, a patient tested in accordance with subdivision (b) and who shows evidence of increased risk of invasive MRSA shall again be tested for MRSA immediately prior to discharge from the facility. This subdivision shall not apply to a patient who has tested positive for MRSA infection or colonization upon entering the facility.

(d) A patient who is tested pursuant to subdivision (c) and who tests positive for MRSA infection shall receive oral and written instructions regarding aftercare and precautions to prevent the spread of the infection to others.

(e) The infection control policy required pursuant to Section 70739 of Title 22 of the California Code of Regulations, at a minimum, shall include all of the following:

(1) Procedures to reduce health care associated infections.

(2) Regular disinfection of all restrooms, countertops, furniture, televisions, telephones, bedding, office equipment, and surfaces in patient rooms, nursing stations, and storage units.

(3) Regular removal of accumulations of bodily fluids and intravenous substances, and cleaning and disinfection of all movable medical equipment, including point-of-care testing devices such as glucometers, and transportable medical devices.

(4) Regular cleaning and disinfection of all surfaces in common areas in the facility such as elevators, meeting rooms, and lounges.

(f) Each facility shall designate an infection control officer who, in conjunction with the hospital infection control committee, shall ensure implementation of the testing and reporting provisions of this section and other hospital infection control efforts. The reports shall be presented to the appropriate committee within the facility for review. The name of the infection control officer shall be made publicly available, upon request.

(g) The department shall establish a health care acquired infection program pursuant to this section.

SEC. 4. Section 1288.55 is added to the Health and Safety Code, to read:

1288.55. (a) (1) Each health facility, as defined in paragraph (3) of subdivision (a) of Section 1255.8, shall quarterly report all cases of health-care-associated MRSA bloodstream infection, health-care-associated clostridium difficile infection, and health-care-associated Vancomycin-resistant enterococcal bloodstream infection, and the number of inpatient days.

(2) Each health facility shall report quarterly to the department all central line associated bloodstream infections and the total central line days.

(3) Each health facility shall report quarterly to the department

all health-care-associated surgical site infections of deep or organ space surgical sites, health-care-associated infections of orthopedic surgical sites, cardiac surgical sites, and gastrointestinal surgical sites designated as clean and clean-contaminated, and the number of surgeries involving deep or organ space, and orthopedic, cardiac, and gastrointestinal surgeries designated clean and clean-contaminated.

(b) The department's licensing and certification program shall do all of the following:

(1) Commencing January 1, 2011, post on the department's Web site information regarding the incidence rate of health-care-acquired central line associated bloodstream infections acquired at each health facility in California, including information on the number of inpatient days.

(2) Commencing January 1, 2012, post on the department's Web site information regarding the incidence rate of deep or organ space surgical site infections, orthopedic, cardiac, and gastrointestinal surgical procedures designated as clean and clean-contaminated, acquired at each health facility in California, including information on the number of inpatient days.

(3) No later than January 1, 2011, post on the department's Web site information regarding the incidence rate of health-care-associated MRSA bloodstream infection, health-care-associated clostridium difficile infection, and health-care-associated Vancomycin-resistant enterococcal bloodstream infection, at each health facility in California, including information on the number of inpatient days.

(c) Any information reported publicly as required under this section shall meet all of the following requirements:

(1) The department shall follow a risk adjustment process that is consistent with the federal Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN), or its successor, risk adjustment, and use its definitions, unless the department adopts, by regulation, a fair and equitable risk adjustment process that is consistent with the recommendations of the Healthcare Associated Infection Advisory Committee (HAI-AC), established pursuant to Section 1288.5, or its successor.

(2) For purposes of reporting, as required in subdivisions (a) and (b), an infection shall be reported using the NHSN definitions unless the department accepts the recommendation of the HAI-AC or its successor.

(3) If the federal Centers for Disease Control and Prevention do not use a public reporting model for specific health-care-acquired infections, then the department shall base its public reporting of incidence rate on the number of inpatient days for infection reporting, or the number of specified device days for relevant device-related infections, and the number of specified surgeries conducted for surgical site infection reporting, unless the department adopts a public reporting model that is consistent with recommendations of the HAI-AC or its successor.

(d) Health facilities that report data pursuant to the system shall report this data to the NHSN and the department, as appropriate.

SEC. 5. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the

meaning of Section 6 of Article XIII B of the California Constitution.

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AMENDED IN ASSEMBLY JUNE 11, 2007
AMENDED IN SENATE MARCH 12, 2007

INTRODUCED BY Senator Florez

JANUARY 30, 2007

An act to amend Sections 1288.5 and 1288.8 of, and to add Sections 1279.6, 1279.7, 1288.45 and 1288.95 to, the Health and Safety Code, relating to health facilities.

LEGISLATIVE COUNSEL'S DIGEST

SB 158, Florez. Hospitals: patient safety and infection control.

Existing law provides for the licensure and regulation by the State Department of Public Health of health facilities, including general acute care hospitals, acute psychiatric hospitals, and special hospitals, as defined. A violation of these provisions is a crime.

This bill would require health facilities, as defined, to develop, implement, and comply with a patient safety plan for the purpose of improving the health and safety of patients and reducing preventable patient safety events. The bill would require the patient safety plan to establish a patient safety committee composed of health care professionals, and to contain other prescribed elements.

This bill would also require health facilities, as defined, to implement a facility wide hand hygiene program and, beginning January 1, 2011, would prohibit the use of intravenous, epidural, or enteral feeding connections that would fit into a connection port other than the type it was intended for, unless an emergency or urgent situation exists and the prohibition impairs the ability to provide health care.

Existing law establishes the Hospital Infectious Disease Control Program, which, among other things, requires the department and general acute care hospitals to implement various measures relating to disease surveillance and the prevention of health-care-associated infection (HAI). In that regard, the department is required, by July 1, 2007, to appoint a Healthcare Associated Infection Advisory Committee (HAI-AC), composed of specified members, to make recommendations related to methods of reporting cases of hospital acquired infections occurring in general acute care hospitals, as

provided.

Existing law also requires each general acute care hospital, in collaboration with infection prevention and control professionals, and with the participation of senior health care facility leadership, as a component of its strategic plan, at least once every 3 years, to prepare a written report that examines the hospital's existing resources and evaluates the quality and effectiveness of the hospital's infection surveillance and prevention program, including specified information.

This bill would establish a health care infection surveillance, prevention, and control program within the department and require the department, the HAI-AC, and general acute care hospitals, as defined, to take specified actions to implement the program.

This bill would also require, no later than January 1, 2010, specified training for a physician designated as the hospital epidemiologist or infection surveillance, prevention, and control committee chairperson. Also, beginning in January 2010, the bill would require prescribed training for other hospital staff, as specified.

By changing the definition of an existing crime, this bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. (a) The Legislature finds and declares all of the following:

(1) During the past two decades, health-care-associated infections (HAI), especially those that are resistant to commonly used antibiotics, have increased dramatically in California.

(2) There is currently no system within the State Department of Public Health to determine the incidence or prevalence of HAI or to determine if current infection prevention and control measures are effective in reducing HAI.

(3) A significant percentage of HAI can be prevented with intense programs for surveillance and the development, implementation, and constant evaluation and monitoring of prevention strategies.

(4) There is currently inadequate regulatory oversight of hospital surveillance, prevention, and control programs by the department.

(5) The protection of patients in a general acute care hospital is of paramount importance to the citizens of California.

(6) Existing state law requires the department to establish and maintain an inspection and reporting system to ensure that general acute care hospitals are in compliance with state statutes and regulations. Existing law also requires general acute care hospitals receiving funding from the federal Centers for Medicare and Medicaid Services to be in compliance with the federal regulations known as the "conditions of participation."

(b) It is the intent of the Legislature to enact legislation to ensure the occurrence of all of the following:

(1) Establishment of an infection surveillance, prevention, and control program within the State Department of Public Health.

(2) Dissemination of current evidence-based standards of hospital infection surveillance, prevention, and control practices.

(3) Improvement of regulatory oversight.

(4) Reports of the incidence rate of designated HAI are made to the department, and as applicable, to the National Healthcare Safety Network (NHSN) of the federal Centers for Disease Control and Prevention.

(5) Development and implementation of an Internet-based public reporting system on HAI.

(6) Maintenance of a sanitary environment and patient hygiene to avoid transmission of pathogens that cause HAI.

SEC. 2. Section 1279.6 is added to the Health and Safety Code, to read:

1279.6. (a) A health facility, as defined in subdivision (a), (b), (c), or (f) of Section 1250, shall develop, implement, and comply with a patient safety plan for the purpose of improving the health and safety of patients and reducing preventable patient safety events. The patient safety plan shall be developed by the facility, in consultation with the facility's various health care professionals.

(b) The patient safety plan required pursuant to subdivision (a) shall, at a minimum, provide for the establishment of all of the following:

(1) A patient safety committee or equivalent committee in composition and function. The committee shall be composed of the facility's various health care professionals, including, but not limited to, physicians, nurses, pharmacists, and administrators. The committee shall do all of the following:

(A) Review and approve the patient safety plan.

(B) Receive and review reports of patient safety events as defined in subdivision (c).

(C) Monitor implementation of corrective actions for patient safety events.

(D) Make recommendations to eliminate future patient safety events.

(E) Review and revise the patient safety plan, at least once a year, but more often if necessary, to evaluate and update the plan, and to incorporate advancements in patient safety practices.

(2) A reporting system for patient safety events that allows anyone involved, including, but not limited to, health care practitioners, facility employees, patients, and visitors, to make a report of a patient safety event to the health facility.

(3) A process for a team of facility staff to conduct analyses, including, but not limited to, root cause analyses of patient safety events. The team shall be composed of the facility's various categories of health care professionals, with the appropriate competencies to conduct the required analyses.

(4) A reporting process that supports and encourages a culture of safety and reporting patient safety events.

(5) A process for providing ongoing patient safety training for facility personnel and health care practitioners.

(c) For the purposes of this section, patient safety events shall be defined by the patient safety plan and shall include, but not be limited to, all adverse events or potential adverse events as described in Section 1279.1 that are determined to be preventable, and health-care-associated infections (HAI), as defined in the federal Centers for Disease Control and Prevention's National Healthcare Safety Network, or its successor, unless the department accepts the recommendation of the Healthcare Associated Infection Advisory Committee, or its successor, that are determined to be preventable.

SEC. 3. Section 1279.7 is added to the Health and Safety Code, to

read:

1279.7. (a) A health facility, as defined in subdivision (a), (b), (c), or (f) of Section 1250, shall implement a facility-wide hand hygiene program.

(b) Beginning January 1, 2011, a health facility, as defined in subdivision (a), (b), (c), or (f) of Section 1250, is prohibited from using an intravenous connection, epidural connection, or enteral feeding connection that would fit into a connection port other than the type it was intended for, unless an emergency or urgent situation exists and the prohibition impairs the ability to provide health care.

SEC. 4. Section 1288.45 is added to the Health and Safety Code, to begin Article 3.5 of Chapter 2 of Division 2, to read:

1288.45. For purposes of this article, the following definitions shall apply:

(a) "Advisory committee" or "HAI-AC" means the Healthcare Associated Infection Advisory Committee established pursuant to Section 1288.5.

(b) "Health-care-associated infection," "health facility acquired infection," or "HAI" means an infection defined by the National Health and Safety Network of the federal Centers for Disease Control and Prevention, unless the department adopts a definition consistent with the recommendations of the advisory committee or its successor.

(c) "Hospital" means a general acute care hospital as defined pursuant to subdivision (a) of Section 1250.

(d) "Infection prevention professional" means a registered nurse, medical technologist, or other salaried employee or consultant who, within two years of appointment, will meet the education and experience requirements for certification established by the national Certification Board for Infection Control and Epidemiology (CBIC), but does not include a physician who is appointed or receives a stipend as the infection prevention and control committee chairperson or hospital epidemiologist.

(e) "MRSA" means methicillin-resistant Staphylococcus aureus.

(f) "National Healthcare Safety Network" or "NHSN" means a secure, Internet-based system developed and managed by the federal Centers for Disease Control and Prevention (CDC) to collect, analyze, and report risk-adjusted HAI data related to the incidence of HAI and the process measures implemented to prevent these infections.

(g) "Program" means the health care infection surveillance, prevention, and control program within the department.

SEC. 5. Section 1288.5 of the Health and Safety Code is amended to read:

1288.5. (a) By July 1, 2007, the department shall appoint a Healthcare Associated Infection Advisory Committee (HAI-AC) that shall make recommendations related to methods of reporting cases of hospital acquired infections occurring in general acute care hospitals, and shall make recommendations on the use of national guidelines and the public reporting of process measures for preventing the spread of HAI that are reported to the department pursuant to subdivision (b) of Section 1288.8.

(b) The advisory committee shall include persons with expertise in the surveillance, prevention, and control of hospital-acquired infections, including department staff, local health department officials, health care infection control professionals, hospital administration professionals, health care providers, health care consumers, physicians with expertise in infectious disease and hospital epidemiology, and integrated health care systems experts or representatives.

(c) The advisory committee shall meet at least every quarter and

shall serve without compensation, but shall be reimbursed for travel-related expenses that include transportation, lodging, and meals at the state per diem reimbursement rate.

(d) In addition to the responsibilities enumerated in subdivision (a), the advisory committee shall do all of the following:

(1) Review and evaluate federal and state legislation, regulations, and accreditation standards and communicate to the department how hospital infection prevention and control programs will be impacted.

(2) In accordance with subdivision (a) of Section 1288.6, recommend a method by which the number of infection prevention professionals would be assessed in each hospital.

(3) Recommend an educational curriculum by which health facility evaluator nurses and department consultants would be trained to survey for hospital infection surveillance, prevention, and control programs.

(4) Recommend a method by which hospitals are audited to determine the validity and reliability of data submitted to the NHSN and the department.

(5) Recommend a standardized method by which an HAI occurring after hospital discharge would be identified.

(6) Recommend a method by which risk-adjusted HAI data would be reported to the public, the Legislature, and the Governor.

(7) Recommend a standardized method by which department health facility evaluator nurses and consultants would evaluate health care workers for compliance with infection prevention procedures including, but not limited to, hand hygiene and environmental sanitation procedures.

(8) Recommend a method by which all hospital infection prevention professionals would be trained to use the NHSN HAI surveillance reporting system.

SEC. 6. Section 1288.8 of the Health and Safety Code is amended to read:

1288.8. (a) By January 1, 2008, the department shall take all of the following actions to protect against HAI in general acute care hospitals statewide:

(1) Implement an HAI surveillance and prevention program designed to assess the department's resource needs, educate health facility evaluator nurses in HAI, and educate department staff on methods of implementing recommendations for disease prevention.

(2) Revise existing and adopt new administrative regulations, as necessary, to incorporate current federal Centers for Disease Control and Prevention (CDC) guidelines and standards for HAI prevention.

(3) Require that general acute care hospitals develop a process for evaluating the judicious use of antibiotics, the results of which shall be monitored jointly by appropriate representatives and committees involved in quality improvement activities.

(b) On and after January 1, 2008, each general acute care hospital shall implement and annually report to the department on its implementation of infection surveillance and infection prevention process measures that have been recommended by the federal Centers for Disease Control and Prevention Healthcare Infection Control Practices Advisory Committee, as suitable for a mandatory public reporting program. Initially, these process measures shall include the CDC guidelines for central line insertion practices, surgical antimicrobial prophylaxis, and influenza vaccination of patients and healthcare personnel. In consultation with the advisory committee, the department shall make this information public no later than six months after receiving the data.

(c) The advisory committee shall make recommendations for phasing

in the implementation and public reporting of additional process measures and outcome measures by January 1, 2008, and, in doing so, shall consider the measures recommended by the CDC.

(d) Each general acute care hospital shall also submit data on implemented process measures to the National Healthcare Safety Network of the CDC, or to any other scientifically valid national HAI reporting system based upon the recommendation of the federal Centers for Disease Control and Prevention Healthcare Infection Control Practices Advisory Committee or to another scientifically valid reporting database, as determined by the department based on the recommendations of the HAI-AC. Hospitals shall utilize the federal Centers for Disease Control and Prevention definitions and methodology for surveillance of HAI. Hospitals participating in the California Hospital Assessment and Reporting Task Force (CHART) shall publicly report those HAI measures as agreed to by all CHART hospitals.

(e) In addition to the requirements in subdivision (a), the department shall establish an infection surveillance, prevention, and control program to do all of the following:

(1) Designate infection prevention professionals to serve as consultants to the licensing and certification program.

(2) Provide education and training to department health facility evaluator nurses and consultants to effectively survey hospitals for compliance with infection surveillance, prevention, and control recommendations, as well as state and federal statutes and regulations.

(3) By January 1, 2011, in consultation with the HAI-AC, develop a scientifically valid statewide electronic reporting system or utilize an existing scientifically valid database system capable of receiving electronically transmitted reports from hospitals related to HAI.

(4) Provide current infection prevention and control information to the public on the Internet.

(5) Beginning January 1, 2011, provide to the Governor, the Legislature, and the Chairs of the Senate Committee on Health and Assembly Committee on Health, and post on the department's Web site, an annual report of publicly reported HAI infection information received and reported pursuant to this article.

SEC. 7. Section 1288.95 is added to the Health and Safety Code, to read:

1288.95. (a) No later than January 1, 2010, a physician designated as a hospital epidemiologist or infection surveillance, prevention, and control committee chairperson shall participate in a continuing medical education (CME) training program offered by the federal Centers for Disease Control and Prevention (CDC) and the Society for Healthcare Epidemiologists of America, or other recognized professional organization. The CME program shall be specific to infection surveillance, prevention, and control. Documentation of attendance shall be placed in the physician's credentialing file.

(b) Beginning January 2010, all staff and contract physicians and all other licensed independent contractors, including, but not limited to, nurse practitioners and physician assistants, shall be trained in methods to prevent transmission of HAI, including, but not limited to, MRSA and Clostridium difficile infection.

(c) By January 2010, all permanent and temporary hospital employees and contractual staff, including students, shall be trained in hospital-specific infection prevention and control policies, including, but not limited to, hand hygiene, facility-specific isolation procedures, patient hygiene, and environmental sanitation

procedures. The training shall be given annually and when new policies have been adopted by the infection surveillance, prevention, and control committee.

(d) Environmental services staff shall be trained by the hospital and shall be observed for compliance with hospital sanitation measures. The training shall be given at the start of employment, when new prevention measures have been adopted, and annually thereafter. Cultures of the environment may be randomly obtained by the hospital to determine compliance with hospital sanitation procedures.

SEC. 8. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

BOARD OF REGISTERED NURSING
Nursing Practice
Agenda Item Summary

AGENDA ITEM: 11.5
DATE: February 20, 2009

ACTION REQUESTED: Information Only: Update on Administration of Insulin by Unlicensed Personnel in Public Schools.

REQUESTED BY: Susanne J. Phillips, MSN, RN, NP, Chair
Nursing Practice Committee

BACKGROUND:
The court has issued a decision in the lawsuit filed by the American Nurses Association (ANA), ANA-California, California Nurses Association, and the California School Nurses Organization in response to the California Department of Education's Legal Advisory asserting that, under specified conditions, unlicensed personnel could administer insulin to students in public schools. The decision affirms the Board's position that administration of insulin is a nursing function that cannot be performed by unlicensed individuals unless authorized by statute. The decision reads in pertinent part:

> *"Respondents' Legal Advisory on Rights of Students with Diabetes in California K-12 Public Schools is invalid and has no force or effect to the extent that it authorizes the administration of insulin to students by school personnel who are not health care professionals licensed to administer insulin within the scope of their practice under the Business and Professions Code or other persons authorized by statute to administer insulin. Respondents lack legal authority under state and federal laws to enlarge the group of persons who may administer insulin under state statutes. In addition, respondents have not complied with the rule-making requirements of the Administrative Procedure Act in authorizing the administration of insulin to students by school personnel who are not authorized to administer insulin under state statutes, an authorization constituting a regulation within the meaning of the APA."*

The Board's previously issued position statement related to insulin administration by unlicensed personnel has been pulled from the website; the attached document is now on the website and includes directions for accessing the court decision, which is also attached.

NEXT STEP:

FINANCIAL IMPLICATIONS, IF ANY: None

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STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

STATE AND CONSUMER SERVICES AGENCY • ARNOLD SCHWARZENEGGER, GOVERNOR

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INSULIN ADMINISTRATION IN PUBLIC SCHOOLS

The court decision has been issued in the lawsuit filed by the American Nurses Association (ANA), ANA-California, California Nurses Association, and the California School Nurses Organization (Petitioners) against the California Department of Education (DOE) (Respondent). Petitioners challenged DOE's Legal Advisory, which provided that, under specified conditions, unlicensed persons not authorized by California law could administer insulin to students in public schools. The decision affirms the Petitioners' position that administration of insulin is a nursing function that cannot be performed by unlicensed individuals unless specifically authorized by statute. The decision reads in pertinent part:

"Respondents' Legal Advisory on Rights of Students with Diabetes in California K-12 Public Schools is invalid and has no force or effect to the extent that it authorizes the administration of insulin to students by school personnel who are not health care professionals licensed to administer insulin within the scope of their practice under the Business and Professions Code or other persons authorized by statute to administer insulin. Respondents lack legal authority under state and federal laws to enlarge the group of persons who may administer insulin under state statutes. In addition, respondents have not complied with the rule-making requirements of the Administrative Procedure Act in authorizing the administration of insulin to students by school personnel who are not authorized to administer insulin under state statutes, an authorization constituting a regulation within the meaning of the APA."

The decision is also consistent with the Board of Registered Nursing's position on this issue.

References

You can view all documents on this case at www.saccourt.com, online services/view civil and probate case info, Case #: 07AS04631

SUPERIOR COURT OF CALIFORNIA

COUNTY OF SACRAMENTO

AMERICAN NURSES ASSOCIATION; AMERICAN NURSES ASSOCIATION/ CALIFORNIA; CALIFORNIA SCHOOL NURSES ORGANIZATION; and CALIFORNIA NURSES ASSOCIATION,

Plaintiffs/Petitioners,

v.

JACK O'CONNELL, STATE SUPERINTENDENT OF PUBLIC INSTRUCTION; and CALIFORNIA DEPARTMENT OF EDUCATION,

Defendants/Respondents.

AMERICAN DIABETES ASSOCIATION, an organization,

Intervenor.

_____/

Dept. 33

No. 07AS04631

JUDGMENT

Petitioners' Second Amended Petition for Writ of Mandate and Complaint for Declaratory and Injunctive Relief came on regularly for hearing in Department 33 of the above-entitled court on November 14, 2008, the Honorable Lloyd G. Connelly presiding. Carrie L. Bonnington and Pamela Allen appeared for petitioners; Robin B. Johansen and Kari Krogseng appeared for respondents; and James M. Wood, Larisa Cummings and Brian Dimmick appeared for intervenor. After considering the parties' pleadings, memoranda of points and authorities, declarations, exhibits and oral arguments in support and in opposition to the petition and

complaint, the court orally stated and explained its decision to partially invalidate respondent's Legal Advisory on Rights of Students with Diabetes in California's K-12 Public Schools ("Legal Advisory").

As more fully set forth in the transcript of the hearing, the court indicated that the Legal Advisory improperly sanctions and authorizes school districts to use, in the absence of an appropriately licensed health care professional, an unlicensed but adequately trained school employee to administer insulin to a student pursuant to the orders of the student's treating physician and in accordance with the requirements of the student's plan under section 504 of the federal Rehabilitation Act of 1973 ("Section 504 Plan") and the student's individual education plan ("IEP") under the federal Individuals with Disabilities Education Act ("IDEA") and Education Code section 56340 et seq. State laws authorize the administration of insulin to a student only by a licensed health care professional acting within the scope of practice for which he or she is licensed under the Business and Professions Code (e.g., a nurse licensed under the Nursing Practices Act, Business and Professions Code section 2700 et seq., to perform services within the meaning of Business and Professions Code section 2725) or by an unlicensed person who is expressly authorized by statute to administer insulin in specified circumstances (e.g., trained school personnel authorized by Education Code section 49414.5 to provide emergency medical assistance to diabetic students suffering from severe hypoglycemia, a foster parent authorized by Health and Safety Code section 1507.25 to administer medically prescribed injections to a foster child in placement if the foster parent has been trained to do so by a licensed health care professional acting within his or her scope of practice, or the parent of a student or an individual designated by the parent to administer insulin to the student pursuant to Business and Professions Code section 2727 and California Code of Regulations, title 5, section 604).

The court rejected the position of respondents and intervenor that respondent has authority to adopt the Legal Advisory pursuant to Education Code sections 49423 and 49423.6. Section 49423 provides for a school nurse or other designated school personnel to assist a student who is required to take prescribed medication during the regular school day, and section 49423.6 requires respondents to develop regulations regarding the administration of medication in public

schools pursuant to section 49423. Nothing in these statutory provisions authorizes respondents or school districts to designate school personnel who are not otherwise permitted to administer insulin by the matrix of state statutory provisions which govern the scope of practice of licensed health care professionals and expressly permit certain unlicensed personnel to administer insulin in specified circumstances. Nor does the *assistance* authorized by section 49423 reasonably encompass the *administration* of insulin; the plain meaning of assistance and administration as well as the legislative history presented by the parties indicate that assistance is distinct from rather than synonymous or interchangeable with administration.

The court also rejected the position of respondents and intervenor that the provisions of the IDEA and section 504, requiring qualified school nurses or other qualified personnel to administer insulin to students in accordance with the students' IEPs and Section 504 Plans, preempt the state statutes delineating the personnel authorized to administer insulin when statutorily authorized personnel are unavailable due to nursing shortages and fiscal constraints. In those circumstances, according to respondents and intervenor, school districts must comply with the superseding requirements of federal law and may designate school personnel who are not statutorily authorized but who are adequately trained to administer insulin.

The court found that the state statutes do not conflict with or impede implementation of the federal requirements for the administration of insulin by qualified personnel. Rather the statutes identify licensed health care professionals and certain unlicensed persons who are qualified to administer insulin, ruling out any basis for federal preemption. To the extent that nursing shortages and fiscal constraints result in a lack of qualified personnel to administer insulin to students in accordance with their IEPs and Section 504 Plans, the Legislature rather than the court must resolve the matter on the basis of policy choices exclusively within the Legislature's purview. The court must enforce the legislative policy choices in the existing statutes delineating the personnel authorized to administer insulin and may not rewrite the statutes to include other school personnel, even if those other personnel have been adequately trained to administer insulin and even though evidence presented in this proceeding indicates that unlicensed persons with adequate training may safely administer insulin.

Finally, the court determined that the portion of the Legal Advisory sanctioning the administration of insulin to students by school personnel not authorized to do so under state statutes is a regulation which has not been adopted in accordance with the rule-making procedures of the Administrative Procedure Act ("APA"), Government Code section 11340 et seq., and therefore is invalid. This portion of the Legal Advisory adds a new category to the seven categories of persons authorized to administer insulin to public school students which are listed in California Code of Regulations, title 5, section 604. The new category meets the APA's definition of a regulation because the category provides a guideline, instruction or rule to be generally applied by school districts in implementing students' IEPs and Section 504 Plans. (See Government Code sections 11340.5, 11342.600.)

WHEREFORE IT IS ORDERED, ADJUDGED AND DECREED that:

1. Respondents' Legal Advisory on Rights of Students with Diabetes in California K-12 Public Schools is invalid and has no force or effect to the extent that it authorizes the administration of insulin to students by school personnel who are not health care professionals licensed to administer insulin within the scope of their practice under the Business and Professions Code or other persons authorized by statute to administer insulin. Respondents lack legal authority under state and federal laws to enlarge the group of persons who may administer insulin under state statutes. In addition, respondents have not complied with the rule-making requirements of the Administrative Procedure Act in authorizing the administration of insulin to students by school personnel who are not authorized to administer insulin under state statutes, an authorization constituting a regulation within the meaning of the APA.

2.. A peremptory writ of mandate shall issue from this court requiring respondents to (a) refrain from implementing or enforcing those portions of the Legal Advisory on Rights of Students with Diabetes in California K-12 Public Schools that sanction and/or authorize the administration of insulin to students by school personnel who are not authorized to administer insulin under state statutes, including the section on page 10 of the Legal Advisory entitled "Reconciliation of State and Federal Law" and all text following category 7 of the "Checklist" on page 13 of the Legal Advisory, and (b) delete those portions of the Legal Advisory.

3. Petitioners shall recover their costs of suit pursuant to rule 3.1700 of the California Rules of Court.

4. The court reserves jurisdiction to hear and determine a motion for attorney fees pursuant to rule 3.1702 of the California Rules of Court.

Dated: DEC 26 2008

LLOYD G. CONNELLY
Judge of the Superior Court